SESSION 3—HEALTH CARE

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KATHLEEN AURE
KATHY SACKMAN

Ralph Berger: First, let me say good morning and welcome to today's session on "Structural Changes in Health Care." It's nice to see so many familiar faces here as well as to meet new ones. Let me introduce my co-panelists to you, and for the sake of time, I am going to do the short-form version of their résumés.

On my left is Kathleen Aure. Kathleen is the Associate Regional Counsel for Kaiser Permanente's Northern California Regional Legal Department. In this capacity she is responsible for a legal staff that handles a wide variety of arbitration and litigation matters for all of Kaiser's bargaining units. Kathleen also manages the health care law section of the department and works in and with the labor and employment section. Additionally, she lectures extensively on employment law topics. I am also very proud to say that Kathleen is a graduate of one of my alma maters, the National Labor Relations Board.

On my right is Kathy Sackman, the Chief Executive Officer of the United Nursing Associations of California, a position she has held since 1978. Kathy helped establish that organization, which currently represents over 6,000 employees. Additionally, Kathy is an International Vice President of the American Federation of State, County and Municipal Employees (AFSCME) and has served as a Vice President and Secretary-Treasurer for the National Union of Hospital and Health Care Employees, AFL-CIO. What is most amazing to me is that until 1983, Kathy worked as a registered nurse on a full-time basis. Obviously, folks, the phrase "spare time" has no meaning to either of my co-panelists.

Earlier this morning you heard Alphonso O'Neil-White discuss what he described as "a revolution in the health care industry." He presented an overview of the structural changes in the field. What we'd like to do now is to discuss the practical impact of those changes on collective bargaining and arbitration. We'd like to see whether those changes have brought new issues to the negotiating

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table and the arbitral forum. If so, what are those issues? How have the parties attempted to deal with them and have the parties' efforts been successful? If not, why not? In particular, we'd like to focus on topics such as the merger of health care providers, skill-mix changes, flex scheduling, and questions related to patient care. If time permits, there are some hypothetical role-plays that have been distributed; we'd like to see how what we've discussed applies to those fact patterns.

Kathleen, let me begin with you.

Kathleen Aure: I think it's safe to say that the train has left the station. And whether the legislators are going to be laying track a mile ahead or just let it go off on its own course is unsettled yet. But we are living in a historic time with respect to health care. The remarks that Don Vial made this morning could be equally applied to health care. It's absolutely true that more than ever health care is becoming a market-driven product. I guess the difference is that it's not that subject to recall or exchange if you have a bad outcome. It's much more people-sensitive, obviously, or tries to be. I would suggest to you, and for those of you who work in the industry as arbitrators know, that the tenor of labor relations is directly related to competition and the market. It's driving the direction of relationships, not only in managed care but also in the more traditional modes of delivery of care. Alphonso O'Neil-White gave you a historical overview of how managed care has evolved, and he's correct when he says that that has been a place where labor unions have been present for many years. But I think it doesn't take much exploration to find that labor unions have been present in nonmanaged care as well as traditional hospitals where the fee-for-service physicians have been working. The competition for the health care dollar is huge, and there is a gigantic imperative to reduce costs on the part of providers, whether they are fee-for-service providers, traditional hospitals, part of a network, or part of a staff model HMO or group model. The imperative is there. In HMOs the employers are asking to see reports and results. They are becoming educated shoppers. That leads, in my view, to the question of quality. How do you maintain quality and still be competitive? I don't think the two are mutually exclusive, but there is a fine balance that must be achieved. And I have to say that we're struggling with it, and I think the unions are struggling with it as well.

In health care, not only is there the competition, but also the advent on almost a daily basis of new technology that changes the

way we treat patients. The old model of care delivery is changing. It is just changing phenomenally and again almost on a real-time basis, it's a virtual reality. Nursing is an example, and Kathy is someone who can trace very eloquently the changes that have occurred. Historically, nursing has been both favored and disfavored by the changes in health care. If you look back, there has been a substantial group of people who would have described nurses as handmaidens. I find that repugnant and incredibly sexist, but probably true. You then move into a model where the registered nurses (RNs) have become the primary caregiver outside of a physician. You move then to a team nursing concept, where you take the RNs as the leaders of teams composed of RNs, licensed vocational nurses (LVNs), and licensed practical nurses (LPNs), depending on the state that you live in. We're now moving toward skill mixes where you have an integrated delivery of health care by a number of different kinds of people. Within, for example, the nursing profession, you've seen what Mr. O'Neil-White referred to as "midlevel practitioners." That's not exactly how I refer to them, but certainly nurse-midwives are a good example. How many women in this room have abandoned the idea that your obstetrical or gynecological services need to be provided by a physician and have gone to nurse practitioners? It's happening in this state on a huge basis, but that is the kind of change we're seeing. Of course, the ominous word "skill mix" has become sort of a lightening rod in the collective bargaining relationship.

I don't want to take much more of your time, but I would suggest to you that as a result of technology and leaps forward in care, there is a record of decreasing hospital stay days. The acuity level of patients we may argue about, but discharges are occurring earlier, and there is more home care. Where you have traditional delivery systems, the tension that this changing practice model creates is obvious. It has given rise to an enormous number of issues that have come before you and your colleagues for decision. One thing that we can accept as a constant is change. There will be lots of change in the future, and employment security, in my view, is going to depend on our ability to be agile and flexible and adapt to new roles and changing methods of delivery. So having said that, I will defer to Ms. Sackman to hear what the union side of the house has to say.

Kathy Sackman: You're going to find that much of what I have to say will track what Kathleen's saying, but probably from a much different perspective. As Ralph has just said, the 6,000 people I

represent are primarily registered nurses. They are in all sectors—public sector, private sector, federal sector—and we represent close to 4,000 Kaiser nurses in southern California. Our international union represents over 60,000 nurses across the country in all practice settings. So there is a lot going on. The health care industry obviously is changing and it's changing very rapidly. We're moving from a patient-focused industry to one in which the bottom line is the dollar. I don't think that's an outrageous statement on the part of the unions; I think everybody knows that. We work in an industry that doesn't make widgets. We're dealing with people; we're dealing with care.

Kathleen talked about quality. One of the first issues that we're facing is who defines quality. Is this quality being defined by the physicians, by the nurses, by health care professionals, or is it, quite frankly, being defined by the people in the three-piece suits from the insurance companies and health plans? Given that, that's one thing you need to look at. The next thing you need to look at is the fact that this industry is unorganized. The American Hospital Association and the hospital industry have successfully kept this industry unorganized. Remember, health care workers did not have the right to join a union until 1974, essentially in nonprofit groups. Then, for 17 years the health care unions went through labor board hearing after labor board hearing to define what the appropriate unit was. So across the country, essentially, if you look at the hospital industry, we're unorganized. In nursing, probably out of 5 million registered nurses there's close to 1.2 million RNs that belong to a union. And I'm defining the American Nurses Association as a union, though they don't. They do collective bargaining in some states, but that's the amount of people that are organized.

Kathleen also talked about how the nurse has come from being seen as a handmaiden to being respected as a highly professional person. Four or five years ago in this country, the hospital association and all of the nursing executives—and I have to say the American Nurses Association—went through this whole gyration that all acute care hospitals had to be essentially staffed completely by RNs. Now that was absolutely crazy. It should not have happened, but it did. At the same time, the delivery of health care was becoming highly technologically improved, and they needed the professional people at that time. You all know about the third rampant nursing shortage that was going on four, five, or six years ago. We had one in the early 1970s, one in the 1980s, and then in the late mid-1980s we had another big nursing shortage.

In the unionized workplaces you as arbitrators were seeing and addressing issues that were kind of interesting. They were issues about qualifications. In other words, the nursing administration decided that anybody who worked in an intensive care unit had to have a bachelor of science in nursing (BSN) and a master of science in nursing (MSN), in addition to the qualifications to be trained to work in an intensive care unit (ICU). So you had the union saying, "Wait a minute, time out. You have to have qualifications, you have to have the additional training, but why do we need a bachelor of science to delineate between a med-surg unit and an ICU staff RN." So depending on what the contract said, that was something that you as arbitrators would address. Job postings. When we organize in hospitals, one of the issues is how people pick and choose who gets what shift. So in contract negotiations we ask for job postings and how those job postings were filled. If you went through an interviewing process just for the employer to pick who they wanted anyhow, then we were before the arbitrator to decide that's not what the language meant in this job posting.

Pay practices. We would negotiate pay practices, and again I'm talking four or five years ago. We would find out that somebody had received a recruitment bonus. The union didn't know the hospital was giving recruitment bonuses. So now you had a failure to bargain and all that kind of nonsense, but the hospitals were trying so very hard to get nurses.

Mandated overtime, a big issue. Nurses were told they had to stay overtime. It didn't matter what the child care issues were. If they left work, they were disciplined for abandoning the patients because these patients deserved the professional care of a nurse.

So now let's fast-forward to what's been going on in the past 18 months. Again, I have to agree with Kathleen, things have changed so very, very fast. It's amazing. We're now looking at shifting from inpatient care to outpatient care. It doesn't matter whether you're talking about the nonprofit hospital down the street or an integrated system like Group Health in Puget Sound or Kaiser Permanente, both of which have an integrated system with their own hospitals. We are shifting care from inpatient to outpatient for cost purposes. Now, I will tell you that some of that makes sense. With the technological changes in health care, people now have gallbladder surgery on an outpatient basis. Patients come in at six in the morning and go home at eight at night, and supposedly most of them do okay. We now have open-heart surgery patients being sent home in four days, and ladies and gentlemen, that's a little crazy!

But that is what is happening. Now it's fine if those people have children or spouses who have some medical background and can recognize when there's a problem, but that's not happening. I mean they're being sent home, and the wife is taught patient care. I have to tell you that I was told by the producer of Dan Rather's program in Washington that he had open-heart surgery four months ago, and he was sent home in four days. His wife was told if he started to bleed from the femoral incision to be sure to apply a lot of pressure. Get a bottle, apply pressure, and call 911. And he said to me, "How is she supposed to do all of that?" But again, we agree with some of those technological changes and don't agree with others.

But I believe the most difficult problem for the unions, and not only the nursing unions, is that we are shifting, because of this whole issue you heard this morning about being competitive, to a system that values the least-costly worker. What worker can we pay the least money to? You're dealing with hospitals, inpatient hospitals, that are replacing the licensed personnel with unlicensed personnel and saying that the patients will be taken care of. And this is what just doesn't make sense at all. The patients in the hospital who are sicker than they've ever been are there only for three or four days. They're highly acute or they wouldn't be in the hospital to start with. So this whole thing about increasing the professional capability of the nurses and making sure they all have BSNs and MSNs and ACLS (advanced cardiac life support) and CLs (clinical ladder)—every initial after our name that we can have and every kind of training we can have—because we're taking care of sick patients. Now we're being told we're not needed. And it's happening in all other settings. It's happening in nursing homes, in extended care, in mental health facilities, in mental retardation facilities. So I'm telling you, the bottom line is dollars. We're looking at getting the least-paid person to take care of patients.

Now, Kathleen talked about pushing the patients out. Utilization is dropping; the drive is on to have any patient who's in the hospital have that utilization figure done, and budgets are driven on that. So staffing and everything goes on to that.

You heard both speakers talk about market share. Unfortunately, large, integrated HMOs, like a Kaiser Permanente or a Group Health in Seattle, organizations that have been around for awhile, have lost market share to the "new kids on the block," like Humana. With all this money in the bank, it will become the "K-Mart of health care." I mean that's what their CEO who's getting paid

$10 billion dollars a year, or some outrageous amount of money as a salary, is saying. He's saying that the HMOs that I feel were very good HMOs—Kaiser Permanente and Group Health in Seattle—are now scrambling because they're starting to lose market share. The average hospital will either be swallowed up by a Humana, which is going to come in and buy them all up, or it will have to market itself to provide these beds to this new HMO group of doctors that just formed down the street and that wants to send its patients somewhere on a capitated basis. They want to pay only $80 a day for the bed—"We don't care, Mr. Hospital, what it costs you, but that's what we're going to pay to use your hospital for our patients." So what do you think the hospital's going to do? They're going to say, "Whoa, wait a minute. We can't pay these wages we've been paying. We've got to have some pay cuts." Crazy, but it's happening.

Plus the replacement issues. We had a march in Washington at the end of March. We had close to 20,000 nurses come on their own. It was not a union-sponsored march, and I don't think the paper made enough about that. A nursing magazine, *Nursing Revolution*, put out the call that nurses should come to Washington. People came to Washington on buses, planes, cars, from no organization. The unions got involved about six weeks later because we found out the lady that put the march together didn't have a march permit. And so AFSCME got in and said, "Whoa, wait a minute, you have to do this in a certain way." So probably out of those 10,000–20,000 nurses, you probably had about 2,000 that were there because the unions brought them. The rest were nonunion nurses from every walk of life, complaining about what was happening to patient care. The issues were replacement and supervision.

So let me very quickly go through what I see as the current issues you are going to face as arbitrators in collective bargaining and arbitration. You're going to be seeing cases on the supervisorial status of nurses—RNs, LVNs, LPNs—based on that Supreme Court decision.[1] And I would suggest you read it. It's a real riot, that whole case. Anyhow, what I did do was to pass out an update on the last couple of regional cases that have come down. The National Labor Relations Board (NLRB) held hearings a couple months ago, and we have not had a decision from the NLRB as yet. But it is good

[1]NLRB v. Health Care & Retirement Corp., 62 USLW 4482, 146 LRRM 2321 (1994).

times for the hospital attorneys because now we're back to the 5-, 7-, 10-, 12-day hearings at the NLRB. So the hospitals, as they're crying all this poor mouth about money, are still going to be spending the legal fees because they want to stop unionization, stop it dead at the trail; they're trying.

The merging of providers. I think Ralph put together a case where unionized and nonunion hospitals merge. What do you do with that?

Skill mix is the issue this year. The problem is, first of all, from a nursing perspective the patients have no idea. Patients are really at everybody's mercy, and when they go into the hospital they plan to have a nurse. Well, ladies and gentlemen, at most nonunion hospitals, you don't have a nurse. We have nonunion hospitals across the country that are changing the name tags to say "Patient Care Provider." That patient care provider may be an RN, an LPN, or an LVN. It may be a trained aide who is certified like in a nursing home and has the degree of training. Or, it may be somebody who was hired and has just three weeks of training. And they're all doing the same thing. So what kind of contract language prevents that from happening? Some contracts have language that says, first of all, there are bargaining unit positions. So if the bargaining unit happens to be LPNs or RNs, now you have a contract violation. You're going to have problems with the health care unions that don't represent nurses with a merger of classifications. I have been actively involved in two skill-mix changes.

One facility came to us and said they wanted to move toward patient-focused care. You're going to hear about patient-focused care. One of the consultants came in with a plan to provide better care at a cheaper cost. And some of it's very true. Why take a patient in a wheelchair down five floors to get an EKG and then bring the patient back to the hospital room? Between the day of admittance and the day of discharge, why does the patient see 25 different people? You need to look at that. Under patient-focused care, we will have to change the skill mix: we will start doing EKGs, chest x-rays, and all the lab work in the unit. So in a way you're doing away with some jobs, and we will have people who will do not only housekeeping chores but also minimal bedside chores. If you're going to do away with a lot of the charting that the nurses have to do, that's a plus for us, but we have a couple of concerns. We don't want anybody laid off; we don't want anybody to lose their job. They're going to change the way they're delivering care because they're now doing primary nursing—all RNs. But we had to figure

out how to do it. We spent 18 months on that project. The other union that represented everybody else agreed that they would work on the project. We did come out with a patient-focused care unit on a large 70-bed medical floor, and we came out with four classifications of caregivers. We didn't lose any RN positions; the LPNs picked up a lot of other duties; the respiratory therapists are probably having some problems because they're doing some bedside care that they never wanted to do before. But it was a good experience.

Contrast that with another facility where we're in the middle of a layoff because we're closing units. In two units, we're changing the way we deliver the care. We currently have on the day shift four RNs and five LVNs, a total of nine licensed personnel. They will be replaced by 14 people, two RNs and 12 patient care assistants. Now we'll layoff all the LVNs and the low senior RNs on that unit and replace them with more people. The LVNs will be totally laid off because the RNs will be put in a float pool. The LVNs will have the right to bid on these assistant positions at $4 less an hour. Ladies and gentlemen, that is happening across this country. That hospital has a union. How many of the grievances filed will go to arbitration? There are also unfair labor practice charges filed because the employer said this is it, it's done, in the middle of a contract. Bad issue you're going to be facing.

Flexible scheduling. Is it in the contract, or is it out of the contract? Five years ago, we did a lot of 10- and 12-hour shifts because they couldn't recruit nurses. It was really great because the nurses worked only three days one week, four the next. It was wonderful. It also cut down on the number of people they needed. If they did 12-hour shifts like those and called them "full-time," it would cut down on one entire body, because you're doing 12 hours instead of three shifts. They paid the overtime, but it still saved them money. Well now, overtime is gone. If you have a collective bargaining agreement that says the overtime is there, employers are saying, "Fine, we'll arbitrate it, but in the meantime we're cutting it out, and we're going either with 12-hour shifts at straight time or no 12-hour shifts." The other side of the coin is we have places that are mandating 12-hour shifts because it lowers the number of people they need, and there's no nursing shortage right now. Remember, you heard me say we're laying off nurses and other health care workers. We are also going to a part-time status for quite a few people. The hospitals now are saying, "We can't afford to pay full-time benefits. But if you want a job, we'll tally your

20 hours, and we expect you to be available for the rest of the week." And of course, there's no standby. Because of concession bargaining or "rip-out" bargaining, contracts that have been there for 20 years are now being decimated.

Merit versus seniority in layoffs. There is a seniority clause, but the employer says, "These medical nurses have been here 20 years, and we really need to leave ICU nurses in, but there's no way we can retrain these people." Some of it's a problem. From the perspective of the nurses' union, we have to look at them every way because if in fact the 10 least-senior people hired are in the operating room, I can tell you, we cannot train a medical nurse for the operating room. They can't report for work there the next day. The operating room probably takes more than six months of training. Well, if the hospital is laying off for whatever reason, they are not going to put that kind of training course on. So that's one issue. Then you get the case of a nurse who works on a medical floor, and the nursing director says, "We're going to start having telemetry on this other medical floor, but you're not qualified." The telemetry course is five days. "But," they say, "we have several new hires who are fully qualified, so we want to put them over there. We don't want to provide the five days." Contractual issue. You're going to be seeing it all around the country, particularly in union places.

Discipline, the report card. You will be seeing discipline because the hospitals and these employers are trying to raise their patients' satisfaction rates. They're doing surveys and calling people at home to ask them how their stay was and whether everybody did what was needed. We're seeing nurses and other health care workers being disciplined because the employer—five days after somebody left the hospital—received a complaint when they called and elicited it. Maybe the complaint is they didn't get their light answered. I don't know whether any of you have seen the ad that some of the nurses associations are placing about the patient here in northern California who called 911 because the light went unanswered. Then you find out that the staffing had been cut by 50 percent on the unit.

You're going to see issues on employee participation, TQM (total quality management) programs. This patient-focused care unit that we participated in voluntarily was a TQM project. But you're going to find that the employers are coming to the unions and saying, "What TQM?" The hospitals are taking the TQM mode and saying, "Redesign the work, redesign the systems and you'll have a better product." The product, of course, is health care. It's

very nice to be empowered. The workers, particularly the lower classifications, think it's wonderful. They're pulled into these meetings; they're told they will have this power to make these decisions. I can tell you in most places, they don't make any decisions. After all is done, the employers say, "Thank you very much," and do what they want to do. So you're going to hear about that.

Two other comments. Doctors are organizing—that's one thing the speaker did say this morning. It just so happens AFSCME represents RNs and doctors. The FPD (Federation of Physicians and Dentists) in Florida is an AFSCME chapter. We are organizing doctors in Chicago.

The other point is the consumer. The comment about the consumer this morning just really blew my mind. What we are seeing is that consumers are many and varied. The consumer is the company that provides the health care for its employees, if it does. The bottom line is the dollar, and they don't really care that the HMO doesn't provide prenatal care, doesn't provide immunization for children. All they know is that they can get this new ABC HMO for $75 a month per employee as opposed to the $300 they're paying with their Blue Cross or one of the higher-paid HMOs. So the consumer is not the average you and me, by any means. The employer says to its employees, "Okay, we have a panel of health providers for you." I can tell you what the average employee is going to pick. If they see an HMO for $75 a month versus Blue Cross at $200 (of which the employer says it will pay only $75 and the employee is going to pay the difference), what's going to happen? You're going to have the people going with the $75 program, which is not a quality health plan. But the consumer doesn't know that. If the consumers are the average citizen, they don't know that.

So I believe that in health care, as long as they don't completely bust us out in the next couple of years, you arbitrators who arbitrate in health care are going to be very, very busy.

Discussion

Ralph Berger: Thank you. And as we say in the business, "From your mouth to God's ears." Okay, before I turn the microphone back to Kathleen, I'd like to state that the Academy is very pleased to announce that we have two visitors from the United Kingdom here. Both are experts in the field of industrial relations and health care. I'd like to call upon Frank Burchill to comment on any of the topics he just heard. Professor Burchill.

Frank Burchill: I don't really want to impose on the Academy's proceedings. I would just say very briefly that what we've heard, certainly from the union's side, is very familiar. In other words, the U.K. is going through all the kinds of technical changes you've been talking about—skill-mix problems, introduction of generic health care assistants, patient-focused care and all that goes with it, the removal of paid overtime, introduction of all kinds of flexibility, etc. Obviously, we're coming from a different historical position. I suppose the major situation at the moment from the collective bargaining point of view is the attempt to decentralize bargaining from the national level to the local level. That's generated a dispute between all of the nursing unions. We don't have the kind of arbitration facilities that you have here. Even where they're agreed to in collective agreements, collective agreements are not legally binding. An employer can withdraw from an arbitration agreement overnight.

Ralph Berger: Thank you. Okay, Kathleen, any response to any of Kathy's "totally impartial, unbiased" remarks?

Kathleen Aure: Well, I think that we are talking about the same things. I think we clearly have some different points of view. I'm somewhat more sanguine about where we're going. I actually was pleased to hear Kathy talk about the one example where they were able to work out this integrated model of care.

First of all, the question about who defines quality is raised constantly. I don't think there is an easy answer because quality is clearly in the eye of the beholder. But, in the end, the patient is the person who will tell you in many respects what quality is. But employers are asking for data. That's new; that hasn't happened before. Organized care and unorganized care are having to report these things. Now as never before, there's a level of consumer awareness whether it be that of the individual purchaser or that of the employer purchaser. So, I think, that is a key to what will drive a lot of the organizations. It's not the kind of thing, I think, that will come before you for decision.

Kathy says hospital work is being shifted to the least-costly worker. I don't agree totally; I certainly think that skill mix does involve an attempt to reduce costs, but you have regulations. You have scope-of-practice issues, and, believe me, the unions that represent the professions and the classifications of licensed workers will not let those issues go unaddressed. So you have to look in your skill mix at what scope-of-practice issues there are and what regulations apply. And you will see those sorts of issues before you,

I think, on a rather regular basis. I disagree again respectfully with my colleague here that nurses are being told that they're not needed. That's not the case. I think that the kind of change that we're seeing is going to ask nurses to approach their practice differently. And the focus of the practice is shifting. I think hospital-based nursing is always going to be there, but we're talking about utilization being reduced and moving into the home care setting. So those are the kinds of issues again that you will be dealing with on a regular basis.

Skill mix. I disagree that people are being asked to do the same thing. In the optimal skill-mix model, you have the best use of the best provider of service in the most economic fashion. Now, that takes some real labor relations work. It doesn't happen by fiat.

The part-time issues are real. They are real because of benefit issues. They are also real in response to life-style issues that are raised by employees. And don't underestimate that for a minute. There is a very large group of employees who only want part-time work. And the benefit issue really becomes a key. And whether they're prorated or nonexistent or full drives much of the part-time thinking, as well as staffing issues.

Merit versus seniority. Seniority is the traditional precept of unions. Those are very difficult issues that are going to call for innovative solutions, because it is the real world. And I would suggest to you for those of you who are local, you don't have to look any further than the city of Berkeley, California, which used to have two hospitals and now has one. In the city of Oakland, California, where outside of the county hospital and the Kaiser Permanente facilities, which stand alone, there were three hospitals; now there's one. The city of San Francisco has shut down a number of hospitals. You've had the merger of two major hospitals, Pacific Presbyterian and Children's Hospital. So these issues are real, and for us to apply an inflexible set of rules and thinking does not recognize the reality of the marketplace. For health care to succeed and to thrive for all parties, for workers, for the managers, and most of all for the consumer, there has to be that kind of adaptability and flexibility. It is going to call upon all of us to practice good labor relations, and you as arbitrators will be asked to fashion solutions in those cases where we can't agree. Ideally, appropriate skill mixes and high-functioning care teams represent success in the area of quality management. It's not just health care that's looking at the concept of quality management; every industry in this country is. The concepts of total quality management and continuous quality

improvement are going to have to be the tools that people carry to work in their bags just like they have carried their other skills that they've learned through their education and through their experience. I would recommend to each of you that you become more acquainted with those concepts because they are big drivers in how hospitals are doing business.

Ralph Berger: Kathy, a rebuttal?

Kathy Sackman: Outcome data, and I should have talked about it also. Kathleen's absolutely right. There has never been outcome data in the health care industry. Some of the studies that have been done in the last couple of years have shown, particularly with some other than Medicare patients, that if you have a higher degree or a higher skill mix of licensed providers involved, you have better outcome data. That means you have a lower mortality rate. That's been one of our frustrations. We are slashing and burning so fast that nobody really knows what is happening with this outcome data—satisfaction data, the infection rate, the readmission rate due to sending people home so fast, how many times are they presenting to the emergency room, how many times are they calling in on the phone to the emergency room because they're having problems that they don't know how to deal with because they really weren't instructed or given a little bit of education to take care of themselves as we're sending them home?

On licensure, Kathleen's absolutely right. You are going to see licensure issues. But I will tell you, although we hear about the regulation and the managers moaning about the regulation in the health care industry, there are no staffing regulations. In the state of California, we have a Department of Health Services that has Title XXII. We are the only state that does regulate the kind or number of staff for our ICUs and our neonatal nurseries. In other words, Title XXII requires that an ICU have a licensed provider for each two patients, and of those licensed providers, 50 percent must be registered nurses. You don't have that in the rest of the country. I was at a conference last weekend in Washington where we had someone speaking to us from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) who made a comment that before the JCAHO comes in for their accreditation review, there's supposed to be a letter posted for everyone to see that patients, anyone, can come to the JCAHO person and say we have a problem, and we don't think this is happening. The place erupted in laughter; none of the nurses ever saw those letters. They're not going to come up, when the JCAHO

person walks around, to say, "We haven't had a nurse on this unit for the past three weeks. Now in the past three days we have four nurses here because they know you're going to be here." That's part of the frustration. Now I'm not saying health care "stinks." There are some good providers; there are some high-quality providers. There are some enlightened managements in my view that try very hard. There are also some enlightened nursing administrators who are being pushed to cut these positions, and they're trying very hard not to do it. Some are willing to meet with the unions. In the American Hospital Association, there are unions, contrary to what you may hear and read, that work very hard to understand. Our union and the nursing associations get so angry at me when I say this. Our union, five years ago, took public positions as to why we moved to all-RN staffing. Why are we laying off LVNs, which is what the hospitals were doing, and replacing them with RNs in the middle of a nursing shortage? It was because the nursing arm of the American Hospital Association, the association and organization of nurse executives, felt the only way care could be delivered was by professional RNs. That is "b.s." There's an appropriate mix, but you must arrive at that mix with the workers involved, and you have to have at the forefront, patient care, not a 10-percent budget cut.

Ralph Berger: Okay, questions from the audience. Yes, sir.

Question: A couple of questions primarily on staffing. My understanding, from what I've read, is that there was an attempt to establish a nurse-patient ratio in California. The effort was met by a response from the hospital association that there had not been any significant change in morbidity or mortality rates; therefore, no harm/no foul. Do you think that we will see any change regarding nurse-patient ratio similar to the requirements of intensive care and neonatal care?

Kathy Sackman: Here in California they're trying to get rid of the ICU regulations that are already in place. The California Hospital Association and the Association of Nurse Executives are very diligently trying to get rid of that. Right now I think the balance of power is with the lobbyists of the American Hospital Association and the California Hospital Association. In California and in the country, I do not think you will see staffing regulations or staffing ratios because people will say it's too expensive, too much regulation; there's too much regulation in this country, and we've got to get rid of the regulations. It's going to be very, very tough. Again, the unions don't have the money, the nursing organizations don't

have the money, the nurses by themselves don't have the money. We know who has the money; it ain't us.

Kathleen Aure: I would just say that it's a little more difficult for me to respond because I represent a group of hospitals that sort of stands away from the Hospital Association. Ultimately, in this state there will not be, for the time being, any further regulations promulgated with respect to staffing, but I don't believe we will see the ICU and the neonatal staffing regs abolished. I could be wrong, but I think that there's a pretty strong body of legislators who have become convinced that at least insofar as those rules are concerned, they should stay.

Kathy Sackman: I just want to make one correction. The American Association of Nurse Executives here in California, two of the high leaders are Kaiser Permanente nursing council directors. So Kaiser Permanente is very much involved with the California Hospital Association and the nursing group of that Association.

Mark Kahn: I'm interested in the list of issues you suggested that will involve an arbitrator. It seems to me that in this collection of changes your concerns really cannot be met by typical grievance arbitration involved with deciding that an existing collective bargaining agreement has been misinterpreted or misapplied. I also don't believe that you people are prepared to place in the hands of a third party these very vital decisions.

Kathleen Aure: I beg to differ. Some of them are before an arbitrator right now. There are staffing issues and skill-mix questions that are the subject of grievances. You have a contract that says if you have a grievance filed and your language says staffing is a working condition, you bet it's before arbitrators.

Mark Kahn: But you're not saying to the arbitrator in those cases to decide what the staffing ought to be or to decide whether management is right or wrong. All you're asking the arbitrator to decide is whether the collective bargaining agreement has been violated. That's a very defensive position, which I understand, but the big changes that have taken place will not be facilitated through traditional grievance arbitration that merely applies the old contract that is being subject to big changes.

Kathleen Aure: I would agree to some extent, if you have the kind of management that you can sit down with to try to work out a deal. Fine. But when you get to the point where the employer is saying, "Full steam ahead," you're going to fall back to the contract and have an arbitrator decide. You may lose in an arbitration, but at least you haven't just given up the ghost. I guess what I'm saying to

you is, you will see these cases whether you think we're right in doing it or wrong in doing it. You will see it.

Ralph Berger: I think Mark is also saying that there is a need to be innovative, and we have to go beyond the traditional grievance procedure under the traditional collective bargaining agreement. As we have these structural changes taking place, there is a need to try to develop an alternative dispute resolution mechanism to deal with them.

Jonathan Liebowitz: I have a question for the panel members that I thought of before Mark's question but it follows very closely. I wanted to ask the panel members, what role, if any, med-arb and the use of conveners can play in dealing with all these ongoing problems. There are two, specifically, that I'd like to focus on—one, of visitation rights of union representatives to the health care facility, and the other, the assignment of nonnursing duties to registered nurses.

Kathy Sackman: In our Kaiser Permanente contract we do use mediation-arbitration, and we've used it quite successfully. We, over the last three-year contract, have been very pleased with it and we've used traditional arbitrators, but we do it as med-arb. I do believe it depends on who the arbitrator is in terms of the ability to work with both sides to gain a mediated settlement.

Visitation rights. I don't think you're going to get anything out of med-arb with that because if the employer is saying you cannot visit, it's going to rely on the National Labor Relations Act. If it's part of what's written in the contract, again, I think it depends on the parties as to the success of med-arb.

On the assignment of nonnursing duties, we're trying to keep a handle on the nursing duties that we're not able to handle right now. But it depends, I would think, on the language. If you're going to med-arb, I don't think you're going to med-arb unless you have some sort of relationship between parties. That's been my experience. If you have a relationship between the employer and the union where they are both confident with going to med-arb and whatever the decision or recommendation that comes out of med-arb, it's going to help parties with their respective constituents.

Kathleen Aure: That pretty much echoes my thought. I think it is the second-best solution. The best, obviously, is when the parties can work it out themselves, but it is far preferable to any other solution, barring lack of agreement from the parties.

Milton Rubin: I don't know whether you know abut the Robert Wood Johnson Foundation Research Programs, which include

research on outcome surveys, particularly in New York state. As a member of the Academy, arbitrator on permanent panels in New York hospitals, I'm impressed that the arbitrator still performs a function by answering a question asked by the hospital and the union. All of your discussions are fascinating, but you haven't told me what you want from the arbitrator. What do you ask of the arbitrator? What is the arbitrator limited to? You give them an issue, an issue such as, "Was the OR [operating room] nurse justifiably discharged and disciplined for leaving the OR when she should not have, period?" These are not questions of health care policies, health care administration; what is the role of the arbitrator at that level?

Kathy Sackman: I think you're talking about just cause.

Milton Rubin: No, that's not the only issue.

Kathy Sackman: No, but I mean just what you said. "What's the role of the arbitrator when an operating room nurse was disciplined for leaving the operating room?" First of all, I would think it's turning on some sort of just cause, depending on what your collective bargaining agreement says. Part of the frustration, I think, with discipline cases before arbitration is that nurses are held up to an extremely high standard, as well we should be. But there is the fact of bringing in mitigating circumstances. A medication was left or you left the operating room because somebody called you. So that's why I say just cause, and it's very difficult. But for lack of anything else, we go to the arbitrator, and hopefully the arbitrator's going to look at the seniority, the past record, and whatever testimony we can bring.

Kathleen Aure: Nurses are not the only people who are being held to a high standard, and I think the issue of just cause is the right issue to be before the arbitrator in those circumstances. Each side has an opportunity to present the facts and circumstances as they believe occurred and any mitigation that should be applied. But we're not, and I think both of us recognize this very deeply, alone in this. Nurses are not alone, hospitals are not alone. We do ask that where we can't agree, arbitrators bring their professional expertise to bear. I see that as an important function, and I will tell you that in the area where I work, which is northern California, the nursing contract is the only contract where we have a panel of arbitrators on whom we agree ahead of time because we look for people who understand our issues. The union does the same thing. We don't go to just anyone to decide professional issues as they relate to nursing. And so I think it is a very important function, and I think it is a heavy burden that we place on you.

Question: My question deals with the use in the health care industry today of alternative dispute resolution in a context other than collective bargaining. If you could address that.

Kathleen Aure: Again, I am speaking from my perspective as an attorney who works in a managed care organization. We use alternative dispute resolution on a very wide basis, not only in employment law, although that's what I will talk about generally here. But we use it in professional liability; we do arbitration for our professional liability cases. That's part of the membership contract. I think alternative dispute resolution is the key to helping business keep its focus where it belongs—which is on moving forward and being successful at every level for all kinds of employees. If you can get to alternative dispute resolution at an early stage before things have had a chance to get out of control, and all of you, I'm sure, are keenly aware of how quickly that happens. The difference is enormous, and when we are sued in the employment context (depending on who the plaintiff's attorney is), the first thing we do is start talking about alternative dispute resolution because it's fast, it's appropriate to many, many cases. It allows people and businesses to get on with what they're there to do.

Dan Brent: I'd like to address the skill-mix issues as they have evolved and ask for a response on the role of the arbitrator where you may have overlapping jurisdictions. For example, in a case where the hospital wants to take away from the EKG techs and give to qualified nurses the job of administering an EKG in a facility where they have one-day stay for surgery. Both parties can do the job. Traditionally, there's been a school of thought that employers can define job classifications, and their duty is to bargain with the union as to what the compensation will be for redefined classifications. Under that traditional notion, an arbitrator is now faced with the union as a grieving party with the burden. In fact, it may be more appropriate in these kinds of cases for the employer to bear the burden, if one is really discussing what's the most efficient way to do it. Obviously, alternative dispute resolution, mediation, and other kinds of amicable procedures may be preferable. I think the parties have to explain to arbitrators the degree of creativity they want arbitrators to exercise. Otherwise, we arbitrators are very often loathe to stray very far away from the traditional notion that the moving party has the burden. And in this case, management may, in fact, be best served by bringing in the kinds of expertise that we usually don't see to talk about why a particular skill group or why a mix is more appropriate. What it really does, I think, is change the

position into a quasi-interest setting, rather than a traditional grievance arbitration setting.

Ralph Berger: I know that in that fact pattern the parties would cite to the arbitrator that portion of the contract that says he or she may not change, alter, modify, or in any way desecrate the collective bargaining agreement. Who wants to start first?

Kathleen Aure: One of the things that I said in my opening remarks or rebuttal remarks is that we have to change the way we think. I'm not certain that traditional employers, mine included, are willing to do that. But we have to give the arbitrator the charter to break out of that traditional box to do that because, otherwise, you are going to get exactly that response—you have no authority, you have no right to go beyond certain boundaries that have already been established. And for what it's worth, I do believe that it is worthwhile to have that discussion off the record or perhaps in advance of the arbitration because I think that one of the tensions that we only touched on peripherally today is the kind of tensions that occur between labor unions where you have more than one union in a facility representing different classifications of workers. I'm not so naive as to think that there are some employers who think that's just fine. "Fight it out guys." So that's my response, and I think it's probably a little disingenuous. But that's it.

Norman Brand: I was just going to follow up on Dan's question, and that is what is most useful for accomplishing that end in tripartite arbitration. In those situations where you have a need for a kind of contract adjustment, tripartite arbitration works well because you have the expertise of both sides in with the arbitrator as well as the boundaries that both sides have for acceptability. So that the arbitrator, in making a decision in a tripartite setting, knows just how far the parties really are willing to go and may be able to move them slightly so as to get a unanimous award. But it certainly is a better model for that than single-arbitrator arbitration.

Ralph Berger: Okay folks, if you'll please turn to the second fact pattern because that one deals with skill mix, which we've been talking about. If you haven't had the opportunity to read it, let me summarize. There is an acute care facility, HEALU, which has a collective bargaining agreement with District 1099, a professional association representing registered nurses. The parties are in the second year of a three-year contract. The hospital utilizes a delivery model of primary care utilizing all-RN staffing. For the past six months, as positions have been vacated, postings have gone up, and there is a new category of unlicensed personnel, not necessarily

patient care providers. To protect the innocent or not so innocent, depending on your perspective, we'll call them PTs, patient techs. RNs have been directed to train the PTs in a number of procedures, including administering IVs and giving injections. The union grieves, alleging among other things, that RNs are being required to perform functions that go beyond their job description. The Association argues (1) that the directive will jeopardize patient care, and (2) that it will lead to the Association's eventual demise since additional RNs are slated for layoff. Let's give my co-panelists a rest for a few minutes and let me have your thoughts on how this should be argued and, based on those arguments, how an arbitrator might decide. Do we have any additional arguments that the Association can make? So far they've said, "Mr. or Madam Arbitrator, this directive jeopardizes patient care. The bargaining unit will be decimated unless you issue a cease and desist order." What else can the Association argue here?

Dan Brent: You wonder what your State Health Department has to say.

Ralph Berger: Right, very serious issue. Can the PTs perform these functions that the RNs are being asked to train them in? Any other issues?

Elizabeth Neumeier: There might be an argument to make under the recognition clause in the collective bargaining agreement that would be more persuasive than just "it will lead to the Association's eventual demise."

Ralph Berger: Yes. Any arguments that management can make here?

Question: Yes, if it's a matter of job content, job performance. There's probably some written documents on job content, such as a job description.

Dan Brent: I suppose it could be analogous to a situation where you have phlebotomists and other kinds of people—different categories and classifications of employees who take blood samples either throughout the day or on a limited basis. Say that the limited role of having nonlicensed personnel—give injections or administer IVs—may be permissible under this scope of discretion of the union and the employer. How far that argument can go, I don't know, depending upon the regulatory scheme of the state.

Ralph Berger: What about the patient care issue? How do you handle that? Think about what you really want to put before the arbitrator in terms of jurisdiction. Does the arbitrator have jurisdiction to determine the level of patient care? Any thoughts.

Question: There must be more of the difference between an RN and an LPN. And I've heard of the tendency to minimize the RNs, as a matter of fact, rotating them even in intensive care. Going in as an arbitrator, I would want to know what is the difference in the type of care that an RN provides versus that provided by an LPN.

Ralph Berger: I see we're running a little late. I'm going to ask my co-panelists if there are any concluding remarks they'd like to make.

Kathy Sackman: I would like to point out that every state is different. Depending on where you're practicing, every state is different either with the regulations or the Department of Health Services, whatever they're called. The licensing boards, the delegation, and the state nursing boards are changing now. There are many hearings on delegation. There are about three states that have issued additions to their regs. So you need to be aware of that. I would imagine it'll be presented to you in any of these cases.

Kathleen Aure: I would agree with Kathy, and I would think if you don't hear of those changes in those kinds of cases, you possibly should ask for them because they provide enormous guidance depending on which state you're in.

Ralph Berger: On behalf of the audience, I'd like to thank my co-panelists. And on behalf of my co-panelists, as well as myself, I'd like to thank you all. Take care and enjoy the rest of the day.