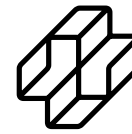


# The Business of Caring



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The American Organization of Nurse Executives

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## Courting MDs: What Is the Nurse Manager's Role?

The buzz about “physician integration” is essentially about patient volumes. In simplest terms, the tradeoff comes down to inpatient versus outpatient and hospitals versus non-hospitals. Traditional hospitals are fighting for market share with imaging centers, surgicenters, urgent care centers—in short, facilities without beds. For hospitals to survive, they must defend and grow their patient volumes (both inpatient admissions and outpatient visits).

One of the most popular strategies in this volume tug of war: integrating or affiliating with physicians.

“Eighty-five percent of tertiary care referrals are still driven by a physician’s recommendation,” says Kriss Barlow, RN, MBA, principal with Barlow/McCarthy, a consulting group focused on hospital-physician solutions.

In other words, engage physicians and patients will follow. Across the country, hospitals are experimenting with a variety of physician integration strategies, including jointly owned ambulatory facilities, employment contracts, and the creation of physician advisory councils. The growing physician shortage only adds to the urgency to build and retain a strong physician

base if hospitals want to continue to provide needed services.

Physicians need hospitals, too. Many physicians are coping with declining incomes and rising expenses—and may be interested in economically agreeable relationships with hospitals. Primary care physicians saw their average net income decline 10 percent over the last decade, and specialists experienced a 2 percent income decline (*Losing Ground: Physician Income, 1995-2003*, Center for Studying Health System Change, June 2006).

As physician integration gains popularity, CNOs and nurse senior executives may find themselves embroiled in discussions about joint ventures, gainsharing arrangements, or other physician integration

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strategies in order to build a patient care program and/or reduce costs. (See the exhibit on page 4 for more.)

Nurse managers may not be involved at such a high level, but their role in engaging physicians—and growing volume—is still vital, experts say.

**Improving Physician Relations**

There are practical, tangible strategies that nurse managers can use to grow volume, say experts. One way is by focusing on physicians who split their referrals and send part of their business to other hospitals.

“Nurses can play a vital role in helping administrators understand physicians’ perceptions of the hospital, as well as their views on competition for services in the market,” says Katrina King, RN, BSN, CRRN, director of network development at Novant Health, Winston Salem, N.C.

Having accurate, objective data makes all the difference when responding to physician perceptions. For example, Dr. Smith may perceive that the hospital “never starts a case on time.” By gathering OR data and case specifics, nurse managers and other administrators can target the problem or correct misperceptions.

“Get your staff actively involved in fixing the problem, as well as communicating the fix back to the physician,” says King.

**Nurses as Physician Advocates**

Hospitals can gain indirectly by helping physicians connect with other physicians—to build their practices. At Indianapolis-based Community Health Network,

**There are practical, tangible strategies that nurse managers can use to grow volume, say experts. One way is by focusing on physicians who split their referrals and send part of their business to other hospitals.**

administrators sought to improve physician relations by launching “Doc to Doc” events to help primary care physicians and specialists meet, so they might generate future referrals and grow their practices.

“As fewer physicians were coming to the hospital, we noticed a disconnect between primary care physicians and specialists,” says Jane Callahan, RN, MBA, executive director of the Exceptional Physician Experience at Community Health Network. “Some doctors were referring patients to other doctors whom they had never met in person before.”

About four times a year, the hospital rents a hotel meeting room and allows physicians to set up tables—like miniature exhibit booths—to introduce themselves to others. The events are popular, sometimes attracting more than 200 physicians at a time. Participation in the event is limited to the hospital’s CEO, president, and physicians.

While nurses aren’t involved in the Doc to Doc events, their role in establishing good physician-hospital relations throughout the network is vital, says Callahan. To many physicians, nurse leaders are the most visible “voice” of the hospital, serving as ambassadors of the organization each day. “Nurse leaders should ask themselves how they can help represent physicians’ interests to the hospital,” says Callahan.

**More Ways Nurses Can Help**

“Improving communications between nurse managers and physicians can have a major impact on the quality of the working

**Web Exclusive**  
Nurse executives: Would you like to learn more about the nuances of joint ventures and other physician affiliation strategies? Read more in-depth information on this topic at [www.hfma.org/boc](http://www.hfma.org/boc). Only subscribers to *The Business of Caring* can access web exclusive material.

environment for all staff members—and patient care,” says Colleen Person, RN, MMA, vice president of Creative Health Care Management, a Minneapolis-based consulting firm focused on building relationship-based care. Here are some ways to make physicians happier—and drive growth in volume.

> Develop your team’s clinical competencies. Physicians want to send their patients to hospitals that provide the best nursing care. A nurse manager can do this by asking physicians about their expectations for care on the unit—and by stating what RNs need from physicians to be successful. Also, managers can routinely review patient care experiences with physicians. In other words, what went well and why? In what ways did the RN-MD relationship have a positive impact on the patient experience?

- > Connect with your vice president of business development, or whomever “owns” physician integration. Network with your chief medical officer, COO, and finance team for ideas on improving physician relations.
- > Step forward and share clinical outcomes and patient satisfaction data with physicians, including those who split referrals. Encourage physicians to shift their business by sharing data on quality, patient satisfaction, and access from your service lines.
- > Make sure you have the staff and equipment to support new physicians. If a new neurosurgeon comes on board, staff the ICU with the right kind of nurses to support these patients. Also, you might identify nurses to serve as “go-to” resources during the crucial first months after a physician comes on board.

**“Improving communications between nurse managers and physicians can have a major impact on the quality of the working environment for all staff members—and patient care.”**

- > Ask referring physicians to serve on unit or service line committees and quality improvement teams. Or seek their opinions before making changes or improvements that will affect patient care delivery.
- > Treat physicians as your customers. Write thank you letters to key physicians or find other ways to support your champions. ☺

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## Physician-Hospital Engagement Strategies

Physician engagement strategies are highly varied, ranging from physician participation on boards and committees to joint ventures, employment, and integrated clinics. The laws and regulations related to joint ventures, gainsharing, and other affiliation strategies (for example, Stark and antikickback) are very complex and change regularly. Nurse executives who are involved in exploring potential physician integration strategies should seek legal and financial advice early and often.

Strategies	Alignment Strength	Advantages	Disadvantages
<b>Physician input through boards and committees.</b> Physicians are invited to be members of hospital committees to provide critical strategic input, decision making, and implementation insights and expertise.	Historically low, but increasing	Low cost; low risk	Longer-term benefits; no or little economic alignment
<b>Medical directorships.</b> The employment of physicians, or granting of titles to physicians, as medical directors of service lines or programs. Medical directors are given managerial authority over clinical and operational issues in specific areas.	Low	Flexible; can include as many physicians as necessary	Can create political conflicts; requires physician time commitment
<b>Income guarantees or forgivable loans.</b> Financial methods to recruit physicians to work for a hospital or in a hospital's service area.	Low	Flexible as long as there is demonstrated need	Short-lived; no guarantees of loyalty or collaboration
<b>Physician hospital organization (PHO) or physician network.</b> A separate legal entity formed by one or more hospitals and one or more physicians or physicians groups with the objective of negotiating contracts with insurance plans and employers. A PHO may provide financial, marketing, and administrative services to its members.	Medium	Some economic alignment	Loyalty is to the contracts, not the other party
<b>Centers of excellence.</b> A state-of-the-art clinical program, generally operated within a hospital, for which top specialists are recruited, and which is recognized for the provision of quality care in the relevant specialty(ies).	Medium	Ties physicians to program; improves service offering	Little economic alignment unless combined with another strategy
<b>IT connection.</b> Hospitals provide physicians with IT systems, hardware, software, and training assistance or equipment.	Medium	Easy to "touch" many physicians	No economic alignment; costly
<b>Management services organization.</b> Organization wholly owned by a hospital (or health system) or jointly owned with physicians, whose function is to provide administrative and support services and/or asset management to physician practices.	Medium	Ties hospital to physicians' business success	Costly; can hurt more than help if not done well
<b>Gainsharing.</b> A hospital shares cost savings related to specific cost-reduction initiatives with designated physician(s)/physician groups; the goal is to encourage the implementation of such initiatives.	Medium	Provides economic benefits for hospital and physicians	Short-lived; takes time to implement
<b>Per-click arrangements.</b> Payment on a per-use, per-service, or unit-of-time basis (for example, a fixed amount per CT scan use). A typical arrangement involves the leasing of equipment by a physician or hospital. The lessee then pays an agreed-upon, per-click fee for use of that equipment.	Medium	Some economic alignment	Represents small piece of overall physician income; recent legal challenges to the approach
<b>Real estate investment.</b> A hospital might offer a physician a small percentage of ownership in a new medical office building in which the hospital is investing. The arrangement can involve many types of real estate, from physician office buildings to the land on which ambulatory centers are built.	Medium/high	Opportunity to include primary care physicians	Limited strategic alignment unless building investment tied to strategy
<b>Participating bond transactions.</b> A transaction in which a hospital allows its physicians to invest in its sponsored, tax-free municipal bonds potentially at a higher-than-usual rate of return (for example to fund a new ambulatory surgery center or a facility replacement). The amount of interest investors earn on these bonds is based on the economic performance of the entity on whose behalf the bonds have been issued.	High	Strong economic alignment	More difficult to sell/ implement

Strategies	Alignment Strength	Advantages	Disadvantages
<b>Leasing or comanagement of facilities and/or service offerings.</b> A lease involves a contractual agreement between two parties (for example, a hospital and a physician group) for use of space, equipment, personnel, etc. One party owns the asset and leases it to the other party. Comanagement typically involves a contractual agreement between a hospital and select physicians for management services of certain service lines.	High	Strong economic and strategic alignment; somewhat easier to unwind if necessary	Contracting potentially complex; requires strong, combined vision and agreement on strategic goals and operating principles
<b>Joint ventures.</b> A short- or long-term arrangement involving risk and benefit sharing between a hospital or health system and one or more entity(ies)—in this case, physicians or physician groups—in order to form and operate a common enterprise for a new or existing purpose. The parties fund the joint venture, such as an ambulatory surgery center, and share the revenues and expenses.	High	Strong economic and strategic alignment	Costly; challenging to implement and govern; may increase operating costs
<b>Physician employment.</b> Employment of physicians—primary care physicians or specialists—through a compensation plan, whether based on salary, salary plus bonus, productivity, or a combination thereof.	High	Strong alignment; minimizes economic risk for physicians	Significant economic and political risk, especially if incentive compensation is not set up properly
<b>Integrated delivery system/clinic model.</b> This involves reorganizing a hospital or health system as a physician-driven clinic organization, representing a new legal entity whose focus is on integration between all levels of care across the continuum. A clinic model is a multi-specialty clinic with fully-employed physicians, such as the Mayo Clinic or the Cleveland Clinic.	High	Physician-driven organization means high collaboration	High hurdles for implementation; must have significant support from all physicians in a community

Source: Kaufman, Hall & Associates, Inc. Skokie, Ill. Reprinted with permission from Warden, J., and Woodward, K., "Creating a Sustainable Physician Strategy," *hfm*, January 2008.

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# How Are You Getting Into Retail Health?

*Retail health clinics, one of the fastest-growing trends in healthcare delivery, are popping up in grocery stores, pharmacies, and shopping malls across the country. Designed to provide quick service to low-acuity patients in a convenient, low-cost manner, the clinics are a big hit with health insurers, employers, patients, and the nurse practitioners who staff them.*

## Case Study 1

### Physicians Warm to Retail Health Clinics

On a weekend at the height of flu season, Elaine Schurr, APRN, saw 54 patients during two, six-hour shifts at Alegent Health's Quick Care clinic in a suburban Omaha grocery store.

She treated most of those patients, and referred two to other care sites: A severely ill, wheezing patient needed to be seen in an emergency department, and an infant younger than the age treated at Quick Care clinics was referred to an urgent care clinic.

Meanwhile, four of the patients Schurr treated had been referred to the grocery store clinic from physician offices where waiting rooms were overrun and the single physician on duty needed relief.

"They know me," says Schurr of the community physicians. "And they know that their patients will get good care."

#### Winning Physicians Over

How quickly things change. When Alegent Health, the largest health system in the Omaha, Neb., area, opened its first Quick Care clinic in early 2006, most physicians were dead set against the idea. Alegent Health operates its retail clinics through partnerships with a regional grocery chain and a regional discount department store.

"The physicians were very fearful that we were going to be in direct competition to

them," says Russ Mulert, operations director for Alegent Health Quick Care, which operates seven retail clinics. "Really, the clinics have turned out to be an extension of their practice, and we built a very good referral relationship back and forth with some of our clinics. A lot of the physicians are advocates for us."

The change in attitude, says Mulert, has come from three things: communication, evidence that nurse practitioners provide high-quality care, and patient referrals to physician practices.

The nurse practitioners who staff the clinics work two days per month in a collaborating physician's office practice. That establishes a good working relationship that has increased physicians' comfort with the Quick Care concept, says Mulert.

Additionally, physicians are notified when their patients have visited a Quick Care clinic, with information about the reason for the visit and the treatment provided.

Perhaps most pivotal to the physicians' acceptance, Quick Care is helping physicians build their practices. Nearly 25 percent of the Quick Care patients had no primary care physician, creating an opportunity for Alegent Health to market its physician services to those patients.

"Alegent Health now has data to show physicians that our new clinics have not affected their volumes at all, and that we've actually brought new patients to the table," says

**"Alegent Health now has data to show physicians that our new clinics have not affected their volumes at all, and that we've actually brought new patients to the table. Our physicians have been able to make more money than they were making before."**

Mulert. "They've been able to make more money than they were making before."

Indeed, more than 1,500 patients have gone on to see an Alegent Health Clinic physician after their first-touch with Alegent Health through the Quick Care Clinics, says Mulert.

The clinics have also brought revenue into the Alegent Health system. Of the roughly 20,000 patients who visited a Quick Care clinic during the first two years of operations, about 40 percent of the Quick Care patients went on to receive additional care at an Alegent Health full-service clinic or one of its nine hospitals in eastern Nebraska and southwestern Iowa. (See the sidebar on page 8 for more ROI information.)

#### Nurses Are Their Own Bosses

Schurr finds that the retail health clinic is a terrific job for a nurse practitioner who enjoys working independently. The trade-off for having sole responsibility for managing a clinic—reception, patient care, and copying insurance cards—is autonomy,

says Schurr. "If you are a patient care person, this is the place for you," she says.

Schurr sees herself at the forefront of this new type of patient care that is very much appreciated by the patients who use it. After that busy Saturday during flu season, the mother of a boy who got a throat culture without spending hours in a physician's waiting room expressed her gratitude in a hand-written note to Schurr. "She said, 'He thinks you are the best, and isn't this a wonderful service. I appreciate your time, and I appreciate your easing his tension,'" says Schurr. "That makes the day worth it."

Elaine Schurr, APRN, is a nurse practitioner at Alegent Health Quick Care in Omaha, Neb. (elaine.schurr@alegent.org). Russ Mulert is operations director at Alegent Health Quick Care (rmulert@alegent.org).

## Case Study 2

### Practitioners Can Focus on the Whole Patient

When Diane Whitcomb, CRNP, moved her career from an emergency department to a grocery store retail clinic, she went from a frenetic atmosphere to a setting where she could really focus on the patient as a whole package. "I get the opportunity to look at patients very holistically," she says. "What kind of jobs do they have? What are their concerns about their children? How is the newly prescribed medicine going to affect their other medicines? How does the illness affect other things in their lives?"

#### A Focus on Prevention

Whitcomb is a family nurse practitioner at CareWorks Convenient Healthcare clinic in a grocery store in Stroudsburg, Pa. Of course, understanding many factors of a patient's life is a goal for most nurses. But many care settings—certainly, an ED—demand full attention be paid to an acute or serious medical situation.

By contrast, patients who come to CareWorks clinics with a severe or chronic

**"Not only can we provide clinical diagnosis and treatment, but we can also take patients on tours through the grocery store to help them design tasty meals that are also healthful. It's a very exciting way to leverage your environment that isn't possible in other settings."**

condition are referred to a Geisinger physician's office, an urgent care clinic, or an ED. The retail clinic is appropriate for preventive care (for example, sports physicals and flu shots) and the treatment of common ailments, such as bronchitis, strep throat, and the flu.

Thus, a typical 15-minute appointment frequently allows Whitcomb to visit with the patient and offer some helpful advice ranging from heart disease prevention to healthy nutrition tips. "We have the opportunity to do a lot of health teaching—which is a real privilege—on how to stay healthy, and on what kinds of things are good for you or maybe not good for you," says Whitcomb.

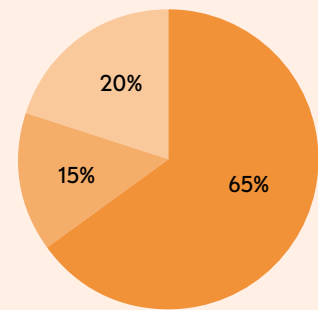
The nurse practitioner who enjoys that kind of interaction is the type of person CareWorks CEO Dean Lin is looking for. CareWorks has opened five clinics so far, with a sixth location under way and more being planned.

#### A "Wow" Service

Lin says the key to success in retail clinics is hiring competent, approachable nurse practitioners to staff them, and the measure of success is patient satisfaction. He takes pride in CareWorks' 99 percent patient satisfaction rating to date.

"Retail and medical establishments rarely achieve this level of customer satisfaction,"

### Where Are Retail Clinics?



■ Drug Store  
■ Grocery Store  
■ Mass Merchandiser

Source: California HealthCare Foundation, 2007.

About 700 retail health clinics were in operation at the end of 2007, and forecasters expect 1,500 clinics to be seeing patients by the end of 2008, according to a study sponsored by the California HealthCare Foundation. Longer-term forecasts range from 2,500 to 6,000 clinics by 2012. Wal-Mart, which currently hosts about 55 health clinics in its stores, recently announced plans to open 400 new retail clinics by 2010.

he says. "This is a 'wow' service, and patients love it so much that they're telling their friends and family."

When patients have a "wow" experience at a CareWorks clinic, their impression of the entire Geisinger Health System is positively affected, believes Lin. While the clinics are still going through a growth phase, the health system as a whole has benefitted. (See the ROI sidebar on page 7.) More than 50 percent of CareWorks patients are new or not active with the health system. Thus, when CareWorks refers patients to other Geisinger services (for example, laboratory, imaging, or emergency services), downstream revenues are generated.

The CareWorks clinics help provide continuity of care for patients. The clinics are equipped with Geisinger's electronic health record technology, so a Geisinger

physician can view a patient's CareWorks<sup>™</sup> visit summary from his or her office.

### Promoting Healthy Living

To move into retail, Geisinger partnered with a major grocery chain with stores in several mid-Atlantic states. That broad geographic presence will allow CareWorks to expand outside of Geisinger's primary service territory. Additionally, Lin intends to increase the range of services that the clinics provide. For example, CareWorks is developing programs that support Geisinger's community health initiatives, such as healthy weight management and smoking cessation.

The retail setting provides convenience and a unique educational opportunity for patients, says Lin. "Not only can we provide clinical diagnosis and treatment, but we can also take patients on tours through the grocery store to teach them how to read food labels and help them design tasty meals that are also healthful," he says. "It's a very exciting way to leverage your environment that isn't possible in other settings."

Diane Whitcomb, CRNP, is a nurse practitioner at CareWorks Convenient Healthcare, a service of Geisinger Health System in Danville, Pa. (dwhitcomb@geisinger.edu). Dean Lin is CEO of CareWorks (dqlin@geisinger.edu).

## Case Study 3 Quick Clinics Help Control Costs

Aurora Health Care opened its first Aurora QuickCare<sup>™</sup> clinic in early 2004, making it the first health system to start a retail clinic. It now operates 19 such clinics, far more than any other U.S. health system.

Why did Aurora Health Care embrace the idea with such enthusiasm? "Our long-term strategy is simplified care for the patients," says Kim Hodgkinson, director of finance and operations for Aurora Health Care Ventures in Milwaukee. "Because of

**One-third of QuickCare<sup>™</sup> patients surveyed would have sought more expensive care at an urgent care clinic or ED if a retail clinic had not been an option. At a minimum, an ED visit costs the patient two to three times what a QuickCare<sup>™</sup> visit costs.**

the hours and the location, the retail clinics are more convenient for patients' lifestyles than the medical center concept."

### Convenience Contains Costs

Aurora QuickCare<sup>™</sup> clinics are located in seven Aurora-owned pharmacies, in seven big-box chain stores, in three regional malls, and in two grocery stores. By making them convenient to where consumers shop, the clinics help keep a lid on health-care costs, says Hodgkinson. She points to two specific reasons:

- > One-third of QuickCare<sup>™</sup> patients surveyed would have sought more expensive care at an urgent care clinic or ED if a retail clinic had not been an option. At a minimum, an ED visit costs the patient two to three times what a QuickCare<sup>™</sup> visit costs, says Hodgkinson.
- > Unnecessary duplication can be avoided through the continuity of care provided by an integrated health system that includes retail clinics. "It's so critical nowadays that all of a patient's providers know what's going on," says Hodgkinson. "That's why we make sure our providers keep the patient's primary care physician informed about the results of the visit."

### Customer Service Skills Needed

Janet Teske, MSN, APN, manager of Aurora QuickCare<sup>™</sup> (the business unit that operates the retail clinics), is assisted by three lead nurse practitioners responsible for staffing and scheduling the clinics in three geographic areas. "That allows me more

## Where's the ROI?

Using a narrow view of return on investment—the amount of profit generated directly from an investment—to judge a retail health clinic might discourage hospital executives from jumping on the bandwagon. But executives at Milwaukee's Aurora Health Care are willing to wait two or three years for a clinic to become profitable.

It takes 14 to 16 patients a day year-round for a clinic to break even, and hitting that target is by no means guaranteed, says Russ Mulert, operations director for Alegent Health Quick Care in Omaha, Neb. "With cold and flu season, we are pretty busy, seeing up to 20 to 30 patients a day," says Mulert. "But that will slow down in the spring, and in the summer, we'll see eight to 10 patients a day."

So why are retail health clinics the fastest-growing healthcare setting in the country? Because these clinics are relatively inexpensive to open. Mulert says it costs about \$100,000 to open a retail health clinic, or less if the retail partner pays for all or part of the construction costs.

Dean Lin, CEO at CareWorks Convenient Healthcare, a venture of Geisinger Health System, says cash collected at a retail clinic is only one factor in measuring its ROI—and not the most important one. Although he thinks retail clinics can achieve profitability, he sees the small clinics accomplishing big goals in the near term:

- > Reducing inappropriate use of the ED, the most expensive healthcare setting, by uninsured patients with minor conditions.
- > Reinforcing the Geisinger brand. Lin considers every CareWorks clinic to be an in-store "billboard" that reminds shoppers of Geisinger's commitment to health care.
- > Increasing the health system's overall market share. By referring patients to other Geisinger services (for example, lab, imaging, or emergency services), the CareWorks clinics generate downstream revenue for the health system.

## Retail Clinics Offer Simple—and Important—Services

Illnesses Treated	Other Services
> Allergies	> Immunizations
> Bladder infections	> Flu diagnosis
> Bronchitis	> Camp and sports physicals
> Diarrhea/vomiting	> Pregnancy tests
> Ear infections	> Suture removal
> Pink eye and styes	
> Sinus infections	
> Strep throat	

time to do the overall management of this new entity that is ever-growing,” says Teske.

Her staff includes 65 nurse practitioners and physician assistants. In addition to clinical competence, Teske looks for clinicians who are comfortable with the responsibilities that come with the unusual healthcare setting. “One of the most important things is the front-end customer service skills, or the personality skills to greet someone,” she says.

Other responsibilities unique to the retail setting: Nurse practitioners and physician

assistants must limit themselves to the services appropriate for the setting. “You may feel at times, ‘Oh, I could treat a migraine, I know how,’” says Teske. “But you have to accept the limited scope of practice.”

There is also some mundane paperwork involved. Currently, the clinicians at Aurora QuickCare™ clinics are responsible for copying patients’ insurance cards and capturing a few pieces of information needed to file insurance claims. As the patient volume expands, Teske expects to add medical assistants at its busiest retail clinics.

## Splitting Time

Quick clinics are expected to proliferate (see the exhibit on page 8). The explosive growth is fueling competition for mid-level practitioners to staff them. Hodgkinson says the competition is increasing the salaries that nurse practitioners can command. To be an attractive employer, Aurora Health Care offers its QuickCare™ staffers the opportunity to split their time between a retail clinic and another venue.

“We have them work at one of our other settings—a physician practice, an urgent care clinic, or some other clinical area—so they stay interested and keep their skills up,” she says. “The biggest thing is not getting bored.” ☺

Janet Teske, MSN, APN, is a nurse practitioner and manager of Aurora QuickCare™ for Aurora Health Care in Milwaukee (janet.teske@aurora.org). Kim Hodgkinson is director of finance and operations for Aurora Health Care Ventures in Milwaukee (kim.hodgkinson@aurora.org).



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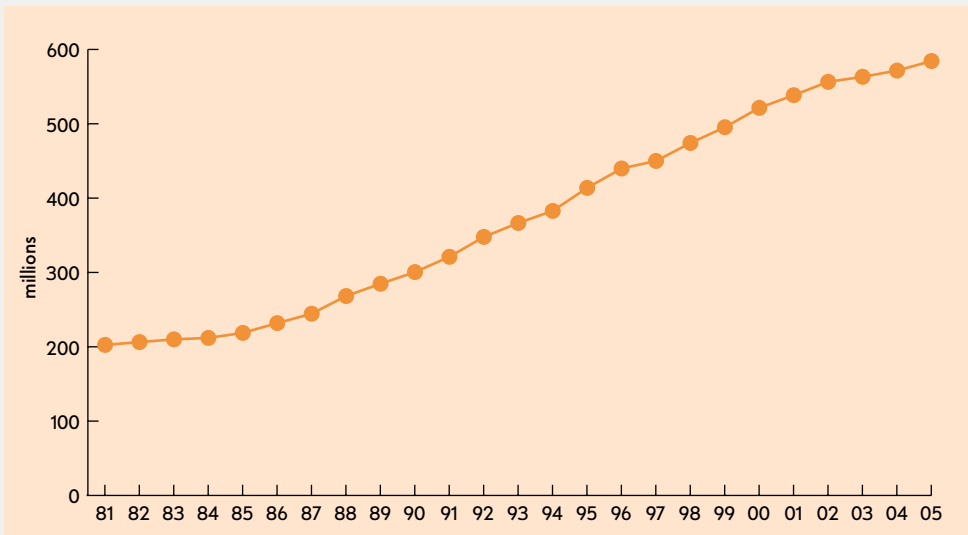
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# The Continuing Growth of Outpatient Services

The shift toward outpatient, same-day care began about 25 years ago. And it's far from over. Hospitals and health systems are still navigating their way through this monumental change toward outpatient delivery—and determining the best way to respond. For instance, some are getting into the retail health business. Others are affiliating with physicians and/or building ambulatory facilities that increase visibility and revenues for the entire health system. Successful hospitals—and patient care programs—are adapting to this new care delivery model and positioning themselves as key players along the continuum of care.

## Outpatients Are Outpacing Inpatients

Outpatient growth in community hospitals, 1981-2005

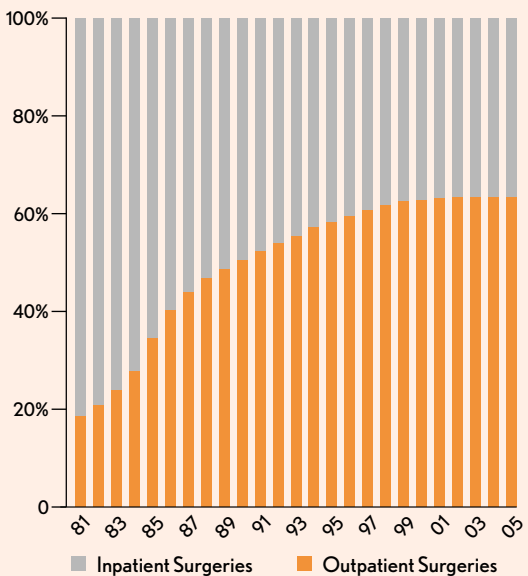


Inpatient admissions have picked up after a decline in the 1990s—but are still being outpaced by outpatient visits. Between 1995 and 2005, outpatient visits increased by about 50 percent. In comparison, inpatient admissions only grew by about 13 percent during this same time period, from about 31 million to about 35 million.

Source: The American Hospital Association and Avalere Health, LLC. *TrendWatch Chartbook 2007*. Reprinted with permission.

## The Majority of Surgeries Now Outpatient

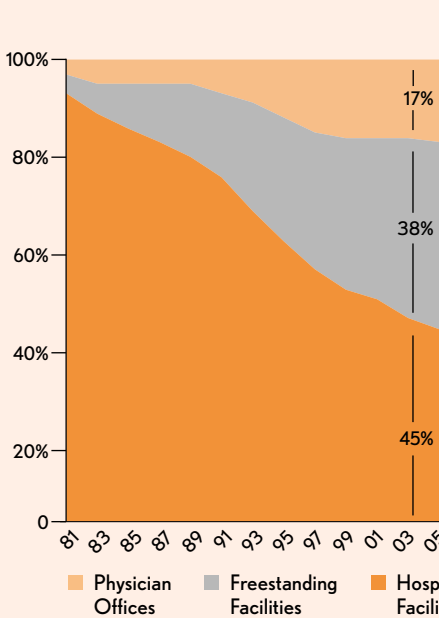
Percentage share of inpatient vs. outpatient surgeries, 1981-2005



Source: The American Hospital Association and Avalere Health, LLC. *TrendWatch Chartbook 2007*. Reprinted with permission.

## Hospitals Losing Surgery Business

Percent of outpatient surgeries by facility type, 1981-2005\*



The percentage of outpatient surgeries performed in hospital-based facilities has fallen by about 10 percent between 1995 and 2005. The number of freestanding surgery centers almost doubled between 2000 and 2005, from 2,864 facilities to 5,095 facilities.

\* From Verispan's Diagnostic Imaging Center Profiling Solution, 2004. 2005 values are estimates.

Source: The American Hospital Association and Avalere Health, LLC. *TrendWatch Chartbook 2006*. Reprinted with permission.

# Managing Non-Nursing Departments

Managing a non-nursing department introduces new challenges for nurse leaders.

**I've just been promoted to a vice president position. In addition to managing nursing departments, I will also be overseeing housekeeping and a few other non-nursing departments. I've only managed nurses in the past, so I don't know much about these other departments. How can I build a rapport with the managers and staff, and help them run their departments well?**

**Sanford:** As clinical support services and other hospital departments are frequently being consolidated for financial reasons, more and more nurse leaders are being called upon to oversee these non-nursing departments. This reorganization makes sense for many hospitals. Many of these departments already work together and support each other, and in some cases, they exchange responsibilities. For example, housekeeping may now take care of some clean-up duties that were once handled by nurses, and nurses may obtain some patient samples that used to be taken by lab staff. If all of these groups are overseen by the same senior manager, that leader can make sure that work is flowing smoothly from one department to the next. Here are some strategies for making that happen.

*Recognize non-nurse roles.* As a nurse, you may have the tendency to focus primarily on the nursing departments, so be careful not to overlook the rest of your staff. When you discuss patient care, you should emphasize that they are a single team. Staff in ancillary departments frequently do not get credit for patient care, despite the important role that they play. Be sure to publicly acknowledge the role that non-nursing staff play in patient care, and make them aware that you understand the importance of their work.

*Be inclusive.* Some leaders talk “team,” but when it’s time to make decisions or change patient care processes, non-nursing departments are left out. You cannot forget that patient care is not solely provided by nurses. Do policies and procedures need to include the work of other departments? Be sure that these groups are invited to meetings and involved in decision making. In addition, make sure that the managers in those departments are given the same leadership development opportunities that nurse managers are.

*Promote interdepartmental dialogue.* Encourage leaders on your team to communicate with each other, preferably proactively and on a regular basis. For example, sit down at least monthly to talk about what is working well and address opportunities for improvement. This will promote teamwork between departments and improve patient care.

*Maintain high standards.* Don’t be afraid to hold the leaders of ancillary areas to the same performance standards as your nursing leaders, even if you don’t have technical expertise or didn’t “grow up” in a non-clinical department. Collaborate with your managers to set realistic goals and measurable accomplishments that complement the activities of the departments.

*Make the rounds.* Just as you make rounds to the nursing departments, you should also visit the other departments that you oversee. This will give you the chance to talk to staff in those areas and learn more about day-to-day operations. In addition, at least once a year, you should shadow someone in each area to see what they really do every day. And don’t forget people who work on shifts other than the day shift.

**“Become familiar with the terms and nuances of your non-nursing areas. Subscribe to their industry journals and attend conferences to stay abreast of trends—the same way that you do with your clinical areas.”**

*Talk the talk.* Become familiar with the terms and nuances of your non-nursing areas. Subscribe to their industry journals and attend conferences to stay abreast of trends—the same way that you do with your clinical areas. You don’t have to be a technical expert in all areas, but make sure that you know enough about their department level challenges and issues to be able to address them and ask informed questions.

*Celebrate other departments.* We have National Nurses Week to help us celebrate the work we do and gain recognition from hospital staff and management. Many ancillary departments have similar observances, such as National Medical Laboratory Professionals Week, and those should be noted by nurse leaders as well. For departments that do not have an official celebration, consider “inventing” one for the staff in your organization. 📌

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Kathleen D. Sanford, RN, MA, DBA, FACHE, is past president of the board of directors of the American Organization of Nurse Executives and senior vice president and chief nursing officer of Catholic Health Initiatives. Do you have a question for Kathleen? Send it to [kathyaone06@yahoo.com](mailto:kathyaone06@yahoo.com).

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# Strategies for Effectively Managing an Intergenerational Workforce

“Young people today have no work ethic.”

“Why should I train that person? She’ll be gone in a year.”

“I can’t work Saturday. I have another life outside this hospital!”

Have you ever heard statements like these from your nurses? Each of these statements reflects the attitudes and beliefs of a different generation of workers. For the first time in history, there are four generations in the workforce. Each of these generations thinks and acts differently, and each generation has prejudices against the others.

In this new climate, the key to creating a cohesive team lies in managing the strengths and weaknesses of each group. Encouraging your nursing staff to appreciate the unique characteristics of their peers will result in a professional work environment that improves recruitment and retention.

The following generational observations can help you in understanding staff nurses and other employees of various ages; however, these are not hard and fast rules. Remember, these generational characteristics don’t fit everyone. Also, it is known that characteristics of generations may cross over. People born on the cusp of two generations may exhibit traits of both generations.

## Characteristics of the Generations

A generation is defined as a group of people who were born during the same generational life span. They share common life experiences, such as historically significant events. The differences between

generations are actually a measure of diversity in the workplace.

*Traditionalists.* The generation of workers over age 64 is called Traditionalists. They identify with traditional family values such as religious faith and country. They grew up with the Great Depression and the advent of Social Security. As workers, they function well in a hierarchical system and have a profound respect for authority. As managers, they want decision making to be top-down, and they may not be comfortable thinking outside the box.

*Baby Boomers.* Baby Boomers are ages 47 to 64. Their generation was defined by the civil rights movement, women’s rights, the Vietnam War, and Watergate. As workers, they want to build consensus and accomplish this by holding frequent meetings. They want to be the heart of the team and crave recognition. As managers, they are good delegators and want people to work as a cohesive team.

Historically, nurses (especially in hospitals) retire or cut their hours between the ages of 53 and 56. Currently, the fastest growing segment of nurses re-entering the workforce falls within the Baby Boomer category. Changes in life expectancy and attitudes toward retirement have led to this shift.

*Generation Xers.* Xers, ages 27 to 47, grew up

with technology, the Internet, and MTV. They watched current events from around the world unfold from their computers and TVs. Because of this exposure to other cultures, they are comfortable with diversity. As workers, Generation Xers do not care about authority and are not motivated by what’s good for the company. They are not comfortable with bureaucracy or micro-management. As managers, they appreciate two-way communication and want to know how things are going. They often survey their staff for feedback on their own performance.

*Generation Y.* The youngest generation currently in the workforce is known as Generation Y (or Nexters), which is made up of people ages 7 to 27. They are the most technologically-savvy generation and are comfortable with multitasking. Like Generation Xers, Nexters are globally minded. One of their biggest priorities is spending time with family.

As workers, they love information. They enjoy continuing education opportunities and networking. They will follow a strong leader, but not one who is perceived to be incompetent. As managers, they believe in allowing people to get the job done on their own schedule as opposed to punching a clock. Experienced nurses should provide positive and constructive input to the younger staff members. New nurses want to excel and will live up or down to expectations.

## Managing the Generations

Mixing the generations in the workplace isn’t easy, and it often requires the manager to act as referee. To build a successful team, you must pay attention to the needs of the different generations. Here are some how-tos.

*Communicate effectively.* One of the most important ways to manage the generation gap is with proper communication. How

does each group want to receive information? For example, Traditionalists do not like emails. They prefer formal documents such as business plans. Generations X and Y prefer the fast pace of electronic communication.

*Manage expectations and motivations.*

Expectations must be managed for each group. For example, Traditionalists and Baby Boomers will gladly give you more than 40 hours a week. However, the younger generations want to finish their work and get on with enjoying life outside the hospital. They appreciate flexible schedules and opportunities for telecommuting. To accommodate the needs of each group, focus on flexibility and involve your nurses in the decisions that affect their units. Seek new scheduling opportunities and care delivery models.

There are also different ways of motivating each group of workers:

- > To motivate Traditionalists, praise them with a handwritten note or an award. They want to receive the gold watch at retirement.
- > Boomers also like formal recognition. They like to see their names in the newspaper. They want to be the team leader.

- > Xers hate micromanagement, so give them a project and let them take ownership of it. They also like to have fun at work and appreciate celebrations.
- > Nexters are motivated by mentors and opportunities for learning. They like the feeling of success and appreciate working with diverse groups.

*Provide appropriate technology.* Technology is an important factor for Boomers, Generation Xers and Nexters. For the younger workers, it is important to provide them with adequate technological resources, such as computers and software.

*Appreciate different work ethics.* Each generation has its own work ethic. One work ethic is not better than the others, just different. It's important to encourage your team members to accept and appreciate the different work styles of each group and the unique contributions that each brings to the table.

*Encourage diversity.* Generational and cultural diversity is another important factor in managing the different generations. We need to think about diversifying our groups of workers to more closely mirror the population at large.

To solidify positive working relationships between the generations, establish multi-generational teams. Challenge organizational paradigms and realize that one size does not fit all. Benefit packages should reflect the needs and desires of each group. Create a "generation friendly" facility by highlighting the strengths of each group.

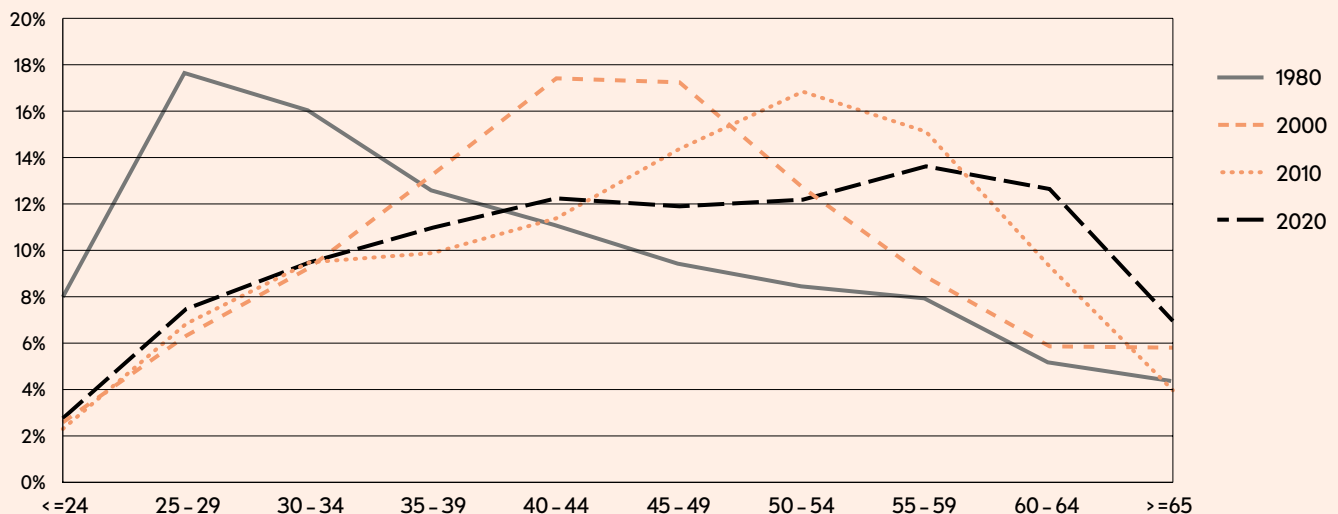
**Maximize Generational Talents**

The first step in creating a solid multi-generational workforce is to determine your own personal biases and eliminate stereotypes. Assess your generational mix and hire more new workers to prepare for the future. You should also develop a program to share generational information with your workforce and establish a plan to maximize the talents of each member of the nursing staff. Encourage each generational group to recognize the positive attributes of the other groups and measure and celebrate outcomes and successes. As you build appreciation and understanding between the generations, you will lay the foundation for a successful, highly-functioning multi-generational team. ☞

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**RN Age Distribution Trends**



Source: *What is Behind HRSA's Projected Supply, Demand, and Shortage of Registered Nurses?*, Health Resources and Services Administration, 2006.

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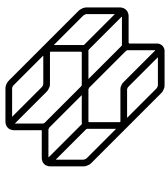
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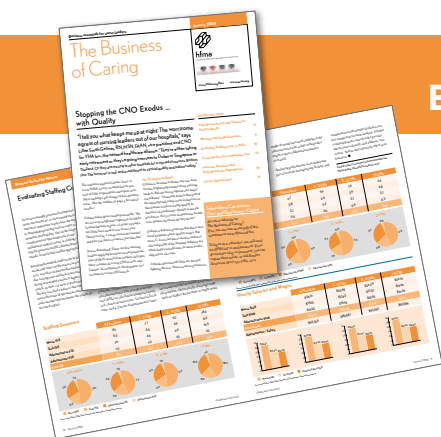
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