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Health Care: Sparrow  
Health System, Lansing,  
Michigan, and Professional  
Employees Council of  
Sparrow Hospital/Michigan  
Nurses Association

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# 8

## Health Care

### **Sparrow Health System, Lansing, Michigan, and Professional Employees Council of Sparrow Hospital/Michigan Nurses Association**

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Employment in the hospital industry continues to increase despite major financial challenges confronting the industry. Expenses in U.S. hospitals doubled over the decade 1986–1996, and these costs are expected to grow at a rate of about 6.5 percent annually (Strunk, Ginsburg, and Gabel 2001). The rapidly rising costs are driving hospitals to exact tough measures to control expenses, including mergers, acquisitions, and closures. Consolidation has reduced the number of hospitals by more than 10 percent, from 6,841 in 1986 to 6,201 in 1996 (Plunkett 2000). However, employment levels in hospitals have not changed correspondingly, with employment in hospitals increasing by more than 500,000 over the level (4.28 million) of the prior decade (Plunkett 2000). Thus, collective bargaining in hospitals occurs within an environment quite different from that experienced by unionized manufacturers, who often are confronted with excess capacity within their industries and shrinking workforce needs.

This case focuses on Sparrow Hospital in Lansing, Michigan. The chapter identifies many of the changes that confronted the hospital over the past few years and examines how the collective bargaining relationship affected the way union and management responded to those changes.

## **DESCRIPTION OF THE BUSINESS**

Sparrow Health System is a nonprofit, community-governed, comprehensive, integrated health delivery and financing system headquartered in Lansing, Michigan. At the heart of the Sparrow Health System is Sparrow Hospital, a 502-bed regional, acute-care facility, and another hospital, the St. Lawrence campus, a formerly independent hospital. Nurses and other professional employees of the health system are represented by the Professional Employees Council of Sparrow Hospital (PECSH), which is affiliated with the Michigan Nurses Association (MNA), an affiliate of the American Nurses Association. Sparrow owns and operates a nursing home in the Lansing area as well as over 30 health-related facilities such as clinics, physician practices, and laboratory draw stations.

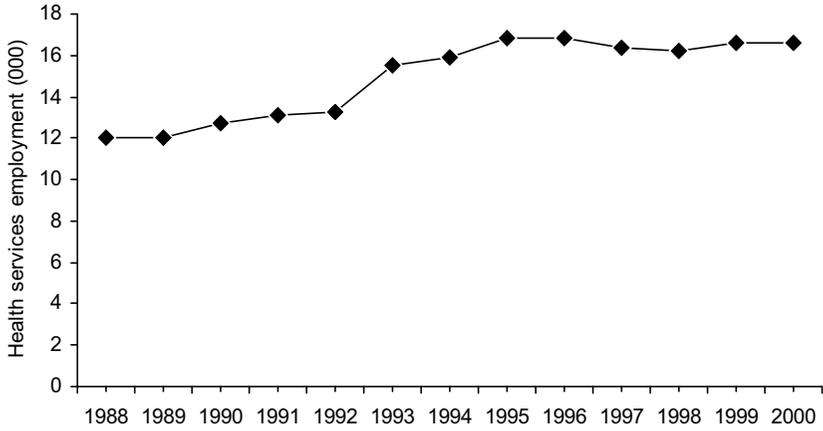
The delivery of health care services is in major transition, as third-party payers (insurance companies, state government, and federal Medicare programs) are demanding reduced—or at least contained—costs, while patients are demanding improved quality, greater accessibility of services or resources, and higher degrees of satisfaction. The industry as a whole is being affected profoundly, and the impact on Sparrow is no exception.

Employment in the health care industry is in the midst of a long-term secular increase. Figure 8.1 shows the trend in health services employment in the Lansing metropolitan area from 1988 to 2000, and Figure 8.2 shows the trend for health services employment nationally. As seen in these figures, both are increasing. Lansing area health care employment increased from about 12,000 to 16,600 between 1988 and 2000, a jump of roughly 38.3 percent. National health care employment during this same period increased from approximately 7.1 million to 10.1 million, an increase of 42.1 percent.

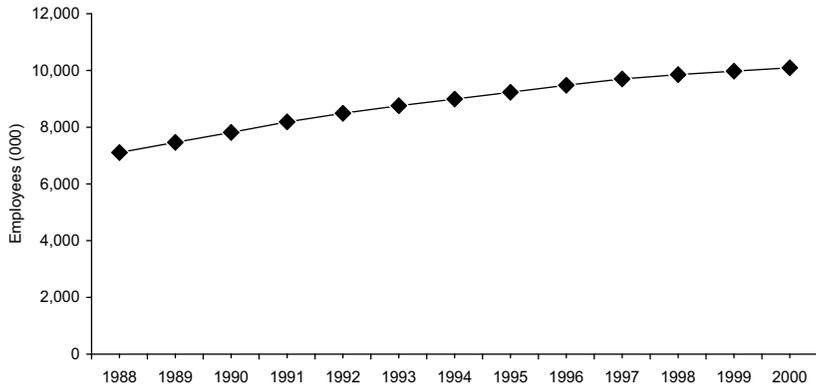
## **HISTORY OF SPARROW HEALTH SYSTEM**

Lansing, the capital of Michigan, is a medium-sized city with a 1996 population of approximately 129,000 (U.S. Bureau of the Census

**Figure 8.1 Health Services Employment in Lansing–East Lansing, Michigan, 1988–2000**



**Figure 8.2 Health Services Employment in the United States, 1988–2000**



1996a) in the midst of a metropolitan area with a 1996 population of approximately 450,000 (U.S. Bureau of the Census 1996b). The city is located in southern lower Michigan, approximately 90 miles northwest of Detroit, the state's largest city, and approximately 90 miles east of Lake Michigan. Other major employers in the area include the State of Michigan, Michigan State University, and General Motors Corporation.

Sparrow was founded in 1896 by a group of civic-minded women who came together to form a community hospital. The 114 charter members of the Women's Hospital Association (WHA) raised \$400, and with that rented a house, hired a doctor and nurse, and devoted their time and resources to keeping their tiny hospital afloat. In the early 1900s, Edward W. Sparrow, a prominent Lansing businessman, donated the money and property that formed the base of today's Sparrow Hospital. Today, the hospital founded by the WHA has become Sparrow Hospital and Health System and serves the health care needs of more than 120,000 people annually.

## **HISTORY AND BACKGROUND OF COLLECTIVE BARGAINING AT SPARROW HEALTH SYSTEM**

Sparrow Health System employs approximately 5,600 people, of which 1,630 are members of PECOSH. The bargaining unit is comprised of all registered nurses and other health care professionals (pharmacists, medical technicians, physical therapists, occupational therapists, dietitians, social workers, and mental health therapists) who are employed by Sparrow Hospital. Members of the bargaining unit may be found working in both of the hospital campuses, as well as in other health system affiliates.

The bargaining unit was first organized in 1988 in response to an increasing number of unilateral decisions by management, particularly with respect to changing work schedules and shifting assignments. Employment trends at Sparrow over the last decade were difficult to determine, as during that time, Sparrow, like many other health care organizations, merged with another hospital (in Lansing) and added many ancillary services, such as laboratories and outpatient facilities.

The collective bargaining relationship began as traditionally adversarial. Contract negotiations in 1991 were very difficult, and a mediator from the U.S. Federal Mediation and Conciliation Service (FMCS) was called in to help reach an agreement. Similarly, in 1994, an FMCS mediator was also called in after a strike vote was taken. The issue at the center of the 1994 conflict was staffing, as many employees—nurses, in particular—were concerned for the well-being of patients. Despite its history of traditional adversarial bargaining, the labor–management relationship changed in 1993, when management began to consult more with union leadership on key decisions that would have an impact on bargaining unit members. These initial cooperative practices were well received, as both parties sensed that a new relationship was needed.

In late 1994, PECSH and Sparrow management, with the assistance of a third party from Michigan State University, met to consider developing a joint labor–management approach to redesigning patient care. The initial meeting had positive results. The parties found that their visions for what they wanted the union–management relationship to become were similar and consequently agreed to a set of principles that would guide their interactions with respect to the redesign process and other matters. Those principles then formed the basis for new provisions in the 1994 collective agreement that created a structure and articulated a purpose for a formal joint labor–management committee. This Mutual Gains Committee (MGC) became the forum through which decisions regarding workplace restructuring that directly affected employees would be made. The MGC ultimately took on a range of issues including staffing and contract interpretation.

## **COMPETITIVE PRESSURES CONFRONTING SPARROW HEALTH SYSTEM AND PECSH**

Hospitals and the health care industry are under tremendous competitive pressures, but it is pressure of a fundamentally different kind than what manufacturing firms face. As noted, unlike manufacturing, employment in health care is increasing. Sparrow’s competitive challenges are thus primarily related to the changing structure of the health

care industry: increased local competition from rival health care organizations, and pressure from third-party payers—insurance companies—to keep fees as low as possible. The increase in surgical centers and clinics has increased competition for health care services and good personnel. Insurance companies continue to pressure hospitals to reduce costs. Moreover, recent reductions in federal Medicare reimbursements, which have resulted in lower payments to hospitals, have added to the cost pressures on hospitals. Customer expectations are driving demands for utilization of emerging technologies and resources and greater satisfaction with respect to the patient and family experience. Sparrow Hospital began to experience these competitive pressures in the early 1990s, though they were not particularly unique to Sparrow.

A major competitive pressure that was unique to Lansing, Michigan, if not to Sparrow, in the 1990s was the merger of two major hospitals in the city and, subsequently, the proposed buyout of that new entity by a large, for-profit hospital chain (Columbia/HCA). That would have led to the creation of one of the first for-profit hospitals in the state. The buyout was ultimately unsuccessful after considerable public outcry and intervention from the State's attorney general. Nonetheless, the consolidation of hospital services prior to the failed buyout effort and the subsequent affiliation of the new merged hospital (and now a much more significant competitor) with a health care system in Flint, Michigan, prompted Sparrow to merge with St. Lawrence Hospital in 1997.

Competitive pressures, reductions in payments to hospitals, and Columbia's attempt to enter the Lansing market prompted other changes at Sparrow. For example, purchasing practices were examined. In some cases, nursing staff felt that they could no longer get the supplies they wanted, only what was cheapest. Employees reported feeling a loss of input and control. Patient-staff ratios increased. Nursing staff believed that some nonnursing personnel were doing tasks for patients that traditionally had been handled by nurses, and they feared that patient care might be compromised. Financial benchmarking practices also took hold to the degree that a number system was applied to the severity of patient illness. This was consistent with what most hospitals were doing to address the lower payment issue. However, some nursing staff were frustrated when the numeric indicators available

were not sufficient to justify dedication of resource levels to a patient. Some nurses feared that their ability to have input into prescribing the care needed for their patients would be eroded. Contentiousness around the contract reflected changes in these business practices.

Sparrow responded to the pressure to reduce costs by benchmarking its costs to other hospitals nationally. The benchmarks furthered the argument that costs at Sparrow needed to be brought in line with hospitals of similar size. Sparrow also responded by increasing nurse–patient ratios to standards in place in other high-performance hospitals. Sparrow also began to experience a shortage of nurses through an interesting twist of fate. A national nursing shortage and a very high patient census resulted in unintended consequences that even Sparrow’s good intentions could not have foreseen. In order to have positions for all staff after the merger, Sparrow left dozens of vacant positions unfilled so that they would be able to make and keep a promise of no layoffs as a consequence of the merger. No one counted on the fact that a number of employees, mostly from the St. Lawrence facility, saw the merger as an opportunity to seek other employment. Because of the tight labor market, they found other employment rather easily, which left Sparrow with many positions unfilled.

## **COLLECTIVE BARGAINING, COMPETITIVENESS, AND EMPLOYMENT PROTECTION/CREATION**

### **Changes in Contract Language**

Management’s proposal to introduce a patient care redesign initiative had a significant impact on collective bargaining and the union–management relationship at Sparrow. Management believed that patient care redesign would improve quality and perhaps even increase patient satisfaction by reducing the number of different employees involved in delivering care. Instead, all services would be delivered through patient-care teams. In 1992–1993, management brought in consultants to help redesign patient care using a model known as “patient-focused care.” Initially, there was no union involvement in selecting consultants or in the process of exploring or designing the

patient-care delivery system. Negative reaction was widespread throughout the Sparrow Health System. Management realized that there would be no acceptance of or commitment to a change this significant if employees were not involved in the effort. Consequently, PECSH leadership was asked to join management in overseeing the effort to redesign the patient-care delivery system. PECSH leadership entered the discussions with an expectation that union and management would work as equals, an idea readily accepted by management. This attitude was consistent with the belief (shared by Sparrow management and staff and PECSH/MNA leadership, and supported by Sparrow's CEO) that people should be involved in making decisions that affected them and their work. Consultants from Michigan State University facilitated an initial meeting between union and management leadership to explore the scope and boundaries of that work, as well as to begin to construct a framework upon which that work would be built. Their discussions resulted in a set of guiding principles that union and management leadership agreed would undergird their work together. The principles also formed the basis for the creation of a joint labor-management mutual gains committee that was negotiated as part of the 1994 collective agreement.

### **Formal Structures**

Sparrow used the Mutual Gains Committee to create a structure and process for redesigning work around a patient-focused care model. The committee visited other organizations, read books, and benchmarked their practices against other hospitals as a way of developing their own model of work organization. The Sparrow model decentralizes some nonnursing services, such as phlebotomy and housekeeping, to the unit level. Typically, the redesigned unit forms teams led by registered nurses (RNs), who delegate responsibilities and monitor performance outcomes. The teams consist of patient care technicians (PCT) (formerly orderlies), who perform uncomplicated respiratory treatments and suctioning, phlebotomy, and EKGs (along with licensed practical nurses). Patient care assistants (PCA), formerly part of the centralized housekeeping staff, are also part of the team on the unit. The PCAs are responsible for cleaning the room, transportation, tray passing and setup, and assisting with beds and baths.

This redesigned work system that integrates functions is supposed to increase patient, physician, and employee satisfaction, as well as improve care and decrease expenses. The teams have yet to be widely implemented across units in the hospital, and their effects seem to be mixed. High patient volume and staff vacancies resulting in tight staffing levels seem to particularly undermine the patient-focused care model. Moreover, the lack of RN training in delegation skills (although various leadership development training sessions were provided) and some RNs' unwillingness to accept authority—and some middle managers' reluctance to give it up—have hindered the implementation of work redesign.

A national nursing shortage, as well as shortages of other key occupations, put pressure on the ability of Sparrow staff to address patient needs and enhance patient satisfaction. This also contributes to additional overtime and recruitment costs and recruitment and retention problems. Indeed, the experience at Sparrow strongly suggests that the success of the patient care redesign is predicated on having sufficient staffing levels. Sparrow and PECSH decided, through the Mutual Gains Committee, to address the shortages jointly. A joint labor-management committee was established to address recruitment and retention of nurses, pharmacists, and other occupations where there is the greatest need. At the same time, the parties maintain their commitment to having sufficient staff coverage at all times. Again, through the Mutual Gains Committee, the parties developed minimal acceptable staffing levels for all units. When staffing falls below the minimal level, a joint committee awards \$200 to the employees in the affected unit, whose responsibility it is to cover the absent or unscheduled employees. The employees in the unit are free to do what they wish with the funds.

When the merger occurred, all nurses and professional health care employees from St. Lawrence were brought in to PECSH in such a way that the St. Lawrence seniority became the seniority within the entire bargaining unit. This was done because management and PECSH believed this was the fair thing to do for the St. Lawrence staff, to build support for the merger and make the new members feel welcome in PECSH. Nonetheless, there was a wage differential between many of the Sparrow employees and the St. Lawrence employees, due in part to the difference in financial performance of Sparrow and St. Lawrence.

Union and management negotiated a one-time, lump-sum bonus to be paid to Sparrow employees, in lieu of a wage increase, so as not to exacerbate the differential. PECSH and Sparrow also negotiated into the 1998 agreement a performance-based, add-on gain-sharing plan. Payout is based on achieving targeted hospital performance.

### **Informal Actions and Programs**

The work redesign efforts have spun off informal applications of the patient care model. In at least one department, the manager and employees are using a participatory process to make changes. Though there has been no formal redesign of that department yet, there is a continual focus on management and staff working together to make operational improvements.

Conversations between PECSH and Sparrow prior to the merger went far to strengthen their relationship, which helped to maintain a positive community image during that period. Management kept the union informed throughout the process and agreed early on to incorporate St. Lawrence professional staff into the PECSH bargaining unit. That led to PECSH working to develop strategies to welcome and integrate new staff into the Sparrow system. On the matter of the potential entry of Columbia/HCA into the Lansing market, PECSH gave definitive support to Sparrow at public hearings to add to the case against entry of the for-profit chain into the local health care market. Other actions enhanced the strength of the labor-management relationship, which is significant in helping Sparrow respond to external competition. During a recent "Nurses Week," PECSH and Sparrow management joined forces in erecting a billboard that combined both a nurses theme and a collaboration theme. For the past several years, Sparrow management has funded several PECSH officers to attend a national conference on "Unions and Health Care." Prior to the merger, both Sparrow and PECSH leadership presented ideas on joint labor-management cooperation to representatives of the Mercy Health Care System, the parent company of St. Lawrence. Both parties were pleased to work together in support of the merger. Their cooperation helped facilitate completion of the negotiations and approval process.

The collective bargaining process itself was affected by the positive experience of working within the Mutual Gains Committee struc-

ture. In the 1998 negotiations, the parties decided to incorporate an explicit interest-based bargaining approach and brought in a third party that was skilled in using this type of model. The consultant taught the bargaining committees how to use the model through a formal education program and then facilitated the bargaining process. An agreement that was satisfactory to all was reached, albeit in the last week of negotiations; when compensation was on the table, bargaining reverted to the much more traditional distributive style. Contract administration has also been affected positively by the cooperative efforts of the parties. There are sincere attempts to settle grievances outside the formal grievance process. In prior years, many managers were trained in non-traditional problem-solving practices. Due to turnover in management and union leadership, the parties recognize a need to recommit time to ensure that problem-solving occurs in a manner consistent with the mutual gains approach.

## **OBSERVATIONS AND CONCLUSIONS**

Though the mutual gains process has had a significant and positive influence on the Sparrow Health System, the impact has been felt most by those in leadership positions. Some union leaders think the process is not as visible to many rank-and-file members. Others have difficulty separating the mutual gains or joint labor-management approach to problem solving or change from the patient-care redesign process itself. For those who have not been involved in work redesign—and that would still be the majority of employees at Sparrow—the only opportunity they would have to see applications of the mutual gains process would be through the day-to-day interactions within their respective departments. Both union and management leadership acknowledge that most middle managers have yet to be trained in interest-based methods and techniques to apply to problems or conflicts that arise. PECSH and Sparrow management have tried to make educating mid- and first-level managers in the basics of the mutual gains or interest-based process a priority, but the competitive pressures that Sparrow has had to face in the past few years have taken a great deal of attention

and diverted resources away from diffusing the mutual gains process throughout the hospital.

For Sparrow Health System, the collective bargaining structure and process has had a positive impact on factors related to competitiveness primarily through the mutual gains provisions in the agreement. The mutual gains process gave all employees, both union and non-union, a voice and a vote in the patient care redesign effort. Indeed, before a redesign is implemented in a unit, it must receive at least a majority vote from all employees in the unit. The mutual gains process has also helped improve problem solving within departments, particularly problems that might otherwise end up as grievances. More managers are likely to support problem solving at the lowest level, and this concept is strongly supported by the human resources department. Over time, many managers have come to a different appreciation of PECSH/MNA and no longer see it as a threat, but rather as a partner in the delivery of high-quality health care. Many rank-and-file members, once they see that management is approachable, go directly to their supervisors to work out problems. Nonetheless, both parties acknowledge that they need to reinvest time and energy in their relationship.

The relationship that PECSH and Sparrow management developed as a consequence of mutual gains has also helped address the threat from external competitors. PECSH and management spoke as a team against the proposed entry of the for-profit Columbia/HCA into the community-based Lansing health care market. PECSH leadership also played a significant role in building acceptance for the merger with St. Lawrence among its own members as well as among the affected workers from St. Lawrence. In addition, PECSH took clear steps to try to integrate St. Lawrence workers into the Sparrow system and to reduce wage differentials that could adversely affect employee morale and turnover rates. Through the Mutual Gains Committee, a committee on recruitment and retention has met several times in an attempt to reduce the shortage of nursing and other personnel, which adversely affects patient care as well as cost of care, two measurements that are important to evaluating the success of redesign efforts.

The degree of job retention and creation that can be attributed to the collective bargaining structure and process at Sparrow is more difficult to assess. PECSH has only been in existence for about 11 years. During that time, some services have expanded and some have con-

tracted. Certainly, the merger with St. Lawrence resulted in a net gain in jobs for the system as a whole, but with the serious nursing and professional staff shortages that exist nationwide, many of those jobs remain unfilled. It is true that some St. Lawrence employees did not make the move to Sparrow when offered the opportunity and took other employment instead, both with other area health care employers as well as outside the health care field entirely. But it does not appear to be the case that these employment choices had much to do with the unionized status of Sparrow Health System. Rather, they seemed to be based on various other factors such as personal preferences, high patient volumes at Sparrow atypical of those at St. Lawrence, high patient acuity, higher starting wages in some cases, and a desire for a different workload than that anticipated at Sparrow.

Job retention is taken very seriously at Sparrow, and the collective agreement and the positive labor-management relations here provided incentive to Sparrow to strengthen job retention practices. Sparrow management learned several years ago when first exploring patient care redesign that the only way they would get the acceptance, if not the cooperation, of nursing and professional staff was to involve them in designing and implementing the changes. Along with that, they also acknowledged that to reduce fears about dislocation, they must address issues of employment security. Management has a standing verbal agreement with PECSH that no person would lose employment with Sparrow Health System as a result of job redesign.

Issues remain, however, that will require additional attention from PECSH and Sparrow management as they continue their efforts to retain or increase their competitive standing. Patient care redesign efforts have affected only a small portion of Sparrow departments and employees. The amount of time needed to redesign patient care systems in a unit was grossly underestimated. Many nurses claim that they do not feel empowered to make decisions, even though there is contractual language to support them. Many managers have not been exposed to the concepts of mutual gains and interest-based approaches to problem solving, so there is disparity in the ways in which people address problems and grievances. In some units, turnover rates are fairly high—not necessarily higher than industry averages, but still high enough to strain staffing levels. The gains achieved by units that have been redesigned are not all that conclusive. Costs are up (perhaps

as a consequence of staffing shortages), while quality indicators, such as infection control and patient satisfaction, are improved. Staff often report, however, that their satisfaction is mixed. Sparrow has long practiced what is known as primary nursing—essentially because Sparrow employed no aides; nurses did everything, affording them the opportunity to develop strong and satisfying relationships with patients. Typically, patient care redesign changes this situation so that the role of the staff nurse is different. For some, this lessens the opportunity to develop strong and satisfying relationships with patients.

Changes in reimbursement patterns from public and private payers continue to drive changes in Sparrow to a degree that significantly controls choices that are made and how work gets done. The amount of paperwork has been increasing profoundly, which results in managers and staff increasing their workload without having additional impact on operations. The excess demands on managers mean that they have less time to look at fundamental changes that would improve work. This leads to managers leaving their jobs because of the perceived loss of impact.

Wage differentials between Sparrow and St. Lawrence employees continue to exist and fester, despite mechanisms in place from the 1998 negotiations to reduce such inequalities. Reports of people working side by side doing the same job yet receiving different salaries are commonplace. The merger with St. Lawrence added many issues to Sparrow's mix and they will likely require attention for some time.

PECSH/MNA and Sparrow management can point to much progress since mutual gains provisions were included in the 1994 collective agreement. These improvements followed from intentional changes in attitudes and degree of support from management and PECSH/MNA leadership toward an improved working relationship in the preceding two years. If all of the competitive issues have not been effectively addressed, then at least the Mutual Gains Committee and the resulting cooperative labor–management process provides a forum with which to address them. The health care industry will continue to offer challenges to organizations like Sparrow as it continues to develop growth strategies in an industry dominated by fewer but larger organizations competing to provide a range of health services, such as outpatient and laboratory services rather than simply inpatient health care. The cooperative labor–management mechanisms that PECSH/

MNA and Sparrow have forged through their collective bargaining process are likely to serve them well as they continue to provide high-quality service to the residents of mid Michigan.

## Notes

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Unless noted parenthetically in the text, the material in this chapter is based on interviews with Aldridge et al. (1999), Barron et al. (1999), Certo et al. (1999), and Daly et al. (1999).

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