Executive Briefing & Exchange
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It's Not About the Money

By Paula Butterfield, PhD

My client Jennifer, an internist and former clinical department chair, was preparing to interview for a position as vice president in her health care system and wanted to talk through some concerns. She had several ideas for positioning herself as a solid candidate, but her real concern was how to frame her lack of financial and budget experience at a system level.

When I asked, "What do you already know about budgeting and financials?" she shot back a worried, "Nothing!" So I pushed her beyond the frame of the current situation. She quickly acknowledged that she'd been working with numbers for years in her medical practice. Sure, the scale was smaller, but she had a foundation upon which to build. When I asked what she does when she doesn't know something, she said, "I call a professional and get his or her input." And how is this different? I asked. She laughed.

There's no better way to ease open doors than to say, "Here's what I want to accomplish. I need your help." It works because it appeals to powerful basic emotional needs like the desire to serve and to contribute. Jennifer's situation was not about the money; it was about her willingness to acknowledge her strengths and limits and actively seek the support she needed.

I reminded her that after she was elected department chair a few years earlier, she'd created a new direction for a medical staff that was struggling. Then she went one-on-one, sharing this new direction and asking for each physician's help in realizing it. For her upcoming interview, we cast this experience and other examples of her leadership into a powerful chronicle of her effectiveness

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EB&E is a service of Executive Women in Healthcare, which produces educational materials and seminars to help women healthcare executives. Executive Women in Healthcare helps leaders differentiate between fads and trends; and helps make connections with other healthcare "Trend Leaders."

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It's Not About the Money (Continued...)

and her ability to engage others in meaningful ways.

Finally, we explored what the interviewers could ask that would trigger her self-doubt and how she could return to a solid, inner place of strength. Jennifer knew what would disarm her. And she knew, from work we'd done when she took the chair position, how to ground herself - physically -- in a place of strength. She'd learned, for instance, how to speak from the belly rather than squeak from the throat. She knew how to find her center of gravity, a physical stance that felt strong and balanced and from which she spoke with authenticity and personal power. Her self-awareness and ability to get centered rekindled her confidence in being able to shape the interview to her advantage.

While she didn't get the position, she did make great strides in shaping her own and others' perceptions of her as a leader. Several months later, she was offered and accepted a position as CEO of a fast-growing home health equipment company. The relationship she formed with the CFO during the interview process helped seal the deal.

Coaching tips:

- When you're unsure in a situation, what do you already know about similar situations that can be useful to you now?
- How do you view not knowing? Sometimes your greatest source of strength is the courage to not know, coupled with the openness to learn.
- Notice where and how confidence feels in your body. Is it a feeling of lightness? Or of groundedness? How does it affect your voice, your muscle tension, the ease with which you move?
- Become familiar with your body's experience of confidence. When your self-doubt is triggered, consciously mimic the feel and sound of your confident self. We're not talking about false bravado here; we're talking about learning to ground yourself in an accurate sense of who you are and what you have to offer.
- Take up a physical activity like yoga or weight lifting to expand your body awareness and develop strength. Both the process and the results will affect your mental and emotional strength as well.

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What Can We Learn From Travelers?

By Dorothy (Dolly) Bellhouse

Traveling (or agency) nurses ("Travelers") are often viewed as a necessary evil. They provide extra "hands" when needed, but can be considered a mixed blessing because the staff on the floor know your organization pays a premium to have them there. And permanent staff are often frustrated because travelers don't know the system.

Let's look at how travelers discover what to do when they arrive at the unit or department to which they are assigned. How do they know what to do? Most traveling nurses have years of experience and are comfortable with ambiguity. Otherwise, they couldn't do their job. But, following a traveler can provide insight into the work at your organization.

How does a traveler know what to do? Is it immediately apparent what to do to order a med...to report a med error...to chart in the computerized medical record...to order PT...to give report? How does a traveler know which form to use for what process or procedure? In other words, how does a traveler know what to do, when to do it and how to do it? And, how do they know if they are doing their work defect-free? They usually are informed of defects when a colleague on the floor notices them using the wrong process or worse, when another department's staff grumpily calls to let them know the traveler did not get them what they needed.

Traveling nurses are experienced and are certainly able to adapt. They have to quickly assimilate to a new organization in order to do their work. But, consider how much time a traveling nurse spends learning the system versus time they spend with patients. If the work on the unit was clear and highly specified, the traveling nurse would be more productive, quicker and would pass fewer defects.

What does it mean to have your work be highly specified? Let's think for a moment about some everyday tasks. Think about a time when you were visiting friends for a few days in their new home. On the last morning of your visit, your friends had to leave early for work and you were on your own to get breakfast and then lock up their house and be on your way. Now, you certainly know how to make coffee and your own breakfast and cleanup afterwards. But did it take longer than usual? Did you find yourself searching for pans, measuring cups, ingredients? Did your friends "orient" you the night before, but in the morning you had trouble remembering all the details? You wanted to be a good guest and put the clean dishes in the dishwasher away, but did you know exactly where to put them. Did you just put them where you thought they should go? Or did you leave the job undone?

These are processes in which you have a lot of experience, but in a new place, it takes you longer and you may miss things or pass a defect by putting dishes or silverware away in the wrong spot. Haven't you had the reverse experience after you've had guests and then cannot find certain utensils or serving pieces for a while until you discover them in a different (from where you would store them) place? Although your friend's kitchen has the same components you have - cupboards, dishwasher, refrigerator, stove, drawers, etc., they are arranged and used differently than at your house, so it may not be clear where to find things and what to do about the clean dishes.

Now, let's go back to the travelers. They certainly know how to take care of patients, but they are working in an unfamiliar "kitchen," if you'll allow the analogy. And they have it a bit harder than you did, because in addition to trying to find things and get what they need to perform their tasks, they are constantly considering the patient. Does Mrs. Jones in 232 look paler than she should? Why hasn't Mr. Barker's physician called back to revise his medications? Ms. Bellhouse in 240 spiked a fever that is concerning. And is Mr. Roberts' wound healing appropriately?

Nurses (travelers or not) should use their experience and memory to assess and care for patients. Wouldn't it be ideal if the work would tell a traveler (and your organization's own staff) what to do? Specifying a nurse's activities would improve the work. For example, forms should clearly tell the person filling them out how to complete them and what to do with the form once completed. Supplies needed for a patient's specific procedure should be stored in one clearly labeled spot and clustered together so it's easy to get everything you need the first time. Documenting on a computerized medical record should prompt you on what to do next and remind you to complete all necessary sections.

Why should nurses (travelers or not) have to remember these kind of details? Specifying work makes it clear what to do when and easier to know if you have a problem. Wouldn't you rather have nurses using their expertise and experience to spend with patients like Jones, Barker, Bellhouse and Roberts?

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END PIECE: Massachusetts Takes the Lead

We have been accustomed to watching healthcare innovation emanate from California. That changed in April when Gov. Mitt Romney signed legislation that made Massachusetts the first state to require everyone to have health insurance-in the same way that drivers must have automobile insurance. It now becomes the only state with universal health coverage

This put Massachusetts in the spotlight and moved it to the forefront of the national debate over how to extend coverage to the uninsured without creating a single government-controlled system. The state has an estimated 550,000 uninsured.

The governor told the news media, "The reason this is so landmark is that we have found a way, collectively, to get all of our citizens insurance without some new government-mandated takeover of a huge new tax program." He said the program would be financed largely with the millions of dollars that the state now spends on uncompensated medical care for poor people who show up at hospitals and clinics without health insurance.

By July of next year, everyone in the state will be required to have health insurance.

Under the plan, the state will offer free or heavily subsidized coverage to poor and lower-income people. Those who can afford insurance, but still refuse to get it, will face escalating tax penalties. For example, they will lose the ability to claim a personal exemption on their state tax returns.

The cost of the program was put at $316 million in the first year, rising to more than $1 billion in the third year, with much of that money coming from federal reimbursements and existing state spending, according to state officials. About $125 million in new money will come from the state's general fund each of the first three years.

The governor vetoed eight portions of the bill including a section of the legislation that would have imposed an annual $295-per-worker fee on businesses that did not provide their employees with coverage. This assessment would have brought in about $45 million a year.

While the legislation represents a major coverage expansion, many questions remain unanswered. Key questions remain about the financial viability of the plan. The ongoing commitment of state and federal funds is critical. The plan projects that more than $200 million over three years will be raised from employer contributions and this funding is also essential. In addition, the employer contribution requirement could be subject to a legal challenge. The effects of a number of changes in insurance law as well as how individuals and employers will respond to the new financial incentives remain unclear.

What are the national implications?

According to Community Catalyst, a national advocacy organization that promotes consumer and community participation in the shaping of a national health system, certain features of the Massachusetts legislation are not easily replicable. Foremost among them is the availability of the federal matching money. While it is not necessarily impossible for any other state to replicate this aspect of the program, special circumstances arising from the Massachusetts waiver put that money on the table and led the Centers for Medicare and Medicaid Services to insist that it be used for coverage.

On the other hand, a provision promoted by Governor Romney to allow purchase of health insurance with pre-tax income could be adopted elsewhere.

The principle of an employer contribution has been established even though the contribution level is low. Along with the near success of California legislation and recent adoption of a Fair Share bill in Maryland, it is clear that there is growing political interest in addressing the role of employers in solving the problem of the uninsured.

The individual mandate is a new and as yet untested approach. Its success will depend on the affordability of plans, the subsidies available to those that must purchase plans and the contributions from state government and employers that fund the subsidies.

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