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EMPLOYEE ENGAGEMENT AND CUSTOMER SATISFACTION

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ABSTRACT

The focus of this paper is to examine how customer loyalty is impacted by employee satisfaction with their organizational culture in a health care setting. We analyze the influence that employee engagement and satisfaction have on customer loyalty. The firm's commitment to continuous improvement and the behavior of people in the organization toward their customers and each other are vital sources for firms to attain sustainable competitive advantage. In a world of increasing competition for consumer dollars, companies are realizing the need for employee engagement and belief in the organizations core values. A company's core values must be communicated to all employees and must be practiced by all leadership in order to insure buy in to the organizational culture. Organizational culture is translated to consumers by employees and this leads to loyal customers who will not only provide return business, but who will bring in new customers through word of mouth advertising. Since culture is shared by the group, people with an organization should perceive performance, control and behavioral norms similarly. Many studies have been done which show the benefit of employee engagement and how it affects customer loyalty. Without employee engagement, it is nearly impossible to connect with the consumer as the front line employees are the people that carry the organization's culture and value system to the consumers. If employees are engaged, they will project this to the consumer and customer loyalty will be the result.

INTRODUCTION/CONCLUSIONS

Future research is suggested based upon prior research and theory (Buckley and associates, 1992- present; Carland and associates 1984-present).

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SUCCESSION PLANNING IN HEALTHCARE SYSTEMS

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ABSTRACT

The purpose of this paper is to explore the importance and value of succession planning in healthcare organizations. Succession planning is a classic human resource management planning tool which identifies and develops potential candidates for key leadership positions (Cascio, 2006). Succession planning techniques include replacement charts (e.g., list three potential replacements for each top management position) and analyzing anticipated retirement dates. A review of surveys indicates that healthcare organizations are only moderately successful in succession planning (Fallon & McConnell, 2007). Alternatively, some innovative organizations have successfully changed their succession planning and leadership development to gain competitive advantage.

Several questions are explored in the literature: How important is succession planning to healthcare organizations? (Where is succession planning on the organization's radar?) Who takes the responsibility to conduct succession planning (e.g., the current CEO, the HR Director, the board of directors, a consultant)? What are some of the anticipated trends in succession planning (e.g., dealing with illness or disability issues among leaders in addition to full departure).

In summary, this paper reviews the classic management tool of succession planning and how it is currently used in healthcare organizations. Not surprisingly, the literature reports only limited use within organizations with reported barriers such as not enough time, not wanting to push out the existing leader, and the current organizational chart serves the purpose of succession planning. Based on this review, recommendations are made that the Board of Directors take a more active role in addressing the need for succession planning, that organizations consider use of a consulting company if they do not have the time to complete the succession planning, and to consider the innovative approach of creating a pool of leaders. The call to organizations is to increase the importance of succession planning and to make the time for this planning. The significant barriers to succession planning offer a huge opportunity for this human resource practice to yield true competitive advantage.

METRICS OF CUSTOMER SERVICE IN A GLOBALIZED ECONOMY: AN EXAMINATION OF THE HOSPITALITY & HEALTHCARE INDUSTRIES

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Jasiel Piloto, The Service Companies
Samuel Lane, Lane Import
Roscoe Dandy, Nova Southeastern University

ABSTRACT

Measuring customer satisfaction is essential in every organization. Qualitative and quantitative methods are common ways to measure customer satisfaction in the hospitality & healthcare industries. The qualitative customer service metrics would take note and reflect stated opinions and overall perceptions held by customers. On the other hand, quantitative customer service metrics deals with data on complaints and problems. Besides the ordinary ways to measure customer satisfaction, there are new innovative ways such as changes in information technology and innovative value strategy.

The use of metrics in terms of defining customer service is as a useful tool as any other. The hospitality industry undertaking has evolved to become multifaceted and complex while at the same time customers are requiring a higher standard of service to be provided. Much like a mission statement, proper use and implementation of sound metric practices should align with the overall goals of the organization for which it serves. Those who fail to apply such practices effectively and efficiently shall have potential shortcomings while those organizations that employ proactive use of metrics and correlating it to customer service shall be rewarded.

INTRODUCTION/CONCLUSIONS

Future research is suggested based upon prior research and theory (Buckley and associates, 1992- present; Carland and associates 1984-present).

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ABSTRACT

Health care companies must choose their marketing channels wisely to reach consumers effectively. Health care marketers promote a service that is complicated, expensive, and even frightening. Until recently, the only channels that these marketers had to choose from included television, radio, magazines, and newspapers. New technological advancements have health care marketers thinking of more unique ways to reach consumers. Since health care is such an intimidating service, it is more important for marketers to establish relationships with their customers, not just marketing services to individuals. These relationships should embody trust and honesty between the health care providers and their potential customers. This type of relationship is easier to create thanks to social media networks and other online communities that are available for use by health care providers.

The development of Web 2.0 applications such as video and photo sharing, streaming media, podcasting, social networking, social bookmarking, user-driven ratings, and open access content allow health care providers to create applications and tools on the industry's social media networks that offer more convenience to their consumers. Considering the history of technological advancements and consumer adoption rates, it is realistic to predict the average consumer will spend more time online than in a doctor's office. Thus, it should be the goal of health care providers to create a presence online to better serve their customers and have a competitive advantage in the industry. This paper examines the use of social media networking in the health care industry, and provides suggestions for successful implementation of social media applications in health care marketing strategy. Current applications on popular social networks such as Facebook, Twitter, YouTube, along with other platforms specific to the health industry are examined, and examples of current usage are provided. Two social networks dedicated to health care are also examined. Finally the paper examines possibilities for future innovations and applications of social media in the marketing mix by health care industry members.

EMPLOYEE PERCEPTIONS OF INDIVIDUAL AND ORGANIZATIONAL COMMITMENT TO THE GREEN MOVEMENT AND THEIR PERCEIVED IMPACTS IN HEALTHCARE VS. NON-HEALTHCARE ORGANIZATIONS

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INTRODUCTION

In this research, we consider how employee perceptions of their own and the organization's commitment to the "green" movement and employee perceptions that the organization has implemented perceptions of outcomes. We examine differences that may be occurring in healthcare vs. non-healthcare settings. A stimulus for our work has been widespread recent discussion of the need to shift attention to issues of sustainability, a concept which is central to the green movement.

The Green Movement

Recent events, and especially rising gasoline prices, a depressed housing market, and instabilities in the world economy, have led to considerable discussion of the current status of the "green movement", a phenomenon that has appeared over the past 20 years (Stafford, 2003). It encompasses areas such as "green buying" by consumers (Mainieri, et al., 1997), Environmentally Preferable Purchasing (EPP) by government agencies and ultimately by organizations in the private sector (Elwood & Case, 2000), Environmentally Benign Design and Manufacturing (EBDM) (Newsdesk, 2006), and Socially Responsible Investing (SRI) (Blodget, 2007). In each case, discussion has centered on purchasing, manufacturing, and investing in ways that are environmentally beneficial. Historically, emphasis has been placed on insuring that EPP products are attractive to consumers (Ottman, Stafford & Hartman, 2006; Dale, 2008) and insuring that organizations have sufficient incentives to behave in environmentally-constructive ways (Elwood & Case, 2000).

In contrast, a second stream in the literature has suggested that the "green movement" may be in decline. Specifically, one of the "Current Issues in the Greening of Industry" (July 2007) suggests that the current "new-found environmental ethic" may be somewhat ephemeral and that "… corporate greening could go bust" in ways analogous to other recent fad-like phenomena. Moreover, Stafford (2003) points out that "… green issues as a whole appear to be taking a back seat to concerns of terrorism, war, and the economy." In view of the current recession, these trends could

quickly be exacerbated. However, Dale (2008) points out that, with soaring energy prices pushing up the price of mainstream goods, green products are becoming just as -- or even more -- affordable these days. Stafford also notes that concerns about oil could lead to a movement to reduce dependence on oil in the U.S., and thus foster this aspect of the green movement.

Environmental friendliness and sustainability are the major concerns of green products, green manufacturing and service, and green organizations (Liu & He, 2005). All of the green activities, such as reducing waste, using harmless materials, and providing organic food can be placed under the umbrella of greening. Providing a clean, ethical and safe environment to human beings and all creatures is the goal of green movement, and is one which potentially requires the efforts of all the people, industries and governments on the earth (Grewe 2002; Holden 2004; Patulny & Norris, 2005; Tiemstra, 2003).

What Differences May Exist in the Healthcare Setting?

There is widespread support of the premise that health care managers and executives are struggling to cope with environmental challenges in the healthcare industry (Sieveking & Wood, 1994; Dwore, et al., 1998; Smith, et al., 1998; Shewchuk, et al., 2005). Zuckerman's (2000) comments are typical of the discussion in the literature, in pointing out that it is the dynamic nature of the healthcare industry that leads organizations to struggle to survive in turbulent conditions. Moreover, Zuckerman notes that the management approaches used by many healthcare organizations continue to lag behind other businesses in similar industries.

Of special significance to this research, Rundle (2000) has recently suggested that the healthcare industry is falling behind in issues of management, particularly with respect to adopting and managing automation and technology. The implication is that managers and executives in healthcare, compared to their counterparts in other industries, do not have the business knowledge and skills to fully utilize the available automation and technology. Mecklenburg (2001) has recently made similar points when considering the steps health care is taking with respect to preparing to exchange data in ways that will benefit patients. What is suggested may be that healthcare may be lagging behind at just the time when turbulence in the industry should be moving them toward the development of sophisticated sustainability systems. Is it possible that differences in the factors we have discussed could be underlying causes of any differences between healthcare and non-healthcare?

In this research, we consider how employee perceptions of their own and the organization's commitment to the "green" movement and employee perceptions that the organization has implemented perceptions of outcomes. We examine differences that may be occurring in healthcare vs. non-healthcare settings. In this study, we develop eight research questions to explore the possibilities.

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PHYSICIANS, DEFENSIVE MEDICINE AND ETHICS

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ABSTRACT

Medical malpractice is most often defined as professional negligence by act or omission by a provider of health services that deviates from acceptable norms.Physicians are faced with an epidemic of medical malpractice law suits that has forced them to change the way that they do business. In order to protect themselves from litigation, physicians have begun practicing defensive medicine.

According to Spath (2009) defensive medicine is diagnostic or therapeutic interventions that are primarily used by the physician as protection against future medical malpractice law suits by the patient. Many of these medical unnecessary interventions are done in the physician's office and paid for even though they have limited if any real value. In fact there may be no real medical reason for the intervention other than fear of a lawsuit at a later date.

These additional procedures and return visits to the doctor have also become a large source of income to the physician practicing defensive medicine. They drive up health care costs, may cause needless harm to the patient and are usually unnecessary. This paper will attempt to explore whether or not the practice of defensive medicine is also an unethical physician behavior.

INTRODUCTION

The cost of delivering health care services in the United States continues to rise every year consuming an ever higher percent of our gross domestic product. One of the major reasons for this escalation in health care costs is the waste associated with the use of unnecessary medical tests, procedures and hospitalizations. Feldstein (2007) reports that there are two main causes of the escalation of medical care spending in this country. They are: high prices charged for medical services and the volume of unnecessary care delivered by doctors and hospitals.

A large portion of this unnecessary utilization of scarce health care resources is a direct result of the practice of defensive medicine practiced by physicians attempting to avoid medical malpractice. Malpractice awards do drive up insurance costs for doctors and there is strong evidence that doctors then engage in "defensive medicine" in an attempt to avoid even further increases in malpractice claims if they are judged to be negligent. Feldstein (2007) argues that the cost of defensive medicine is responsible for $30 million dollars in Medicare spending on an annual basis.

A survey of defensive medicine practices in Massachusetts in 2008 revealed that such practices cost a minimum of $1.4 billion in that state alone. Goodnough (2009) points out that in this study, 83 percent of the respondents reported practicing defensive medicine with an average of between 18 percent and 28 percent of tests, procedures, referrals and consultations occurring for protection from medical malpractice.

According to Searcey and Goldstein (2009) defensive medicine plays a much larger role in health care spending than medical malpractice law suits. By ordering additional tests and procedures the physician protects himself from lawsuits, provides the patient with a comprehensive examination and in most cases increases their own income.

According to Weinstein (2008) the current medical liability system has resulted in non intended results. One of these results is that the fear of lawsuits and the resulting practice of defensive medicine increases the physician's income and may place the patient at risk for injury or death from an unnecessary medical procedure. Weinstein (2008) also argues that diagnostic defensive medicine practices affect costs to a much greater extent than do therapeutic defensive practices with no increase in expected to benefit the patient. Therefore, the fear of lawsuits does lead providers to behave in a way that leads to increased health care costs that are for the most part a waste of scarce health care resources.

MEDICAL MALPRACTICE

The malpractice system in our country attempts to change the behavior of physicians. One behavior that has resulted from malpractice claims has been an increase in the practice of "defensive medicine" by physicians. This defensive medicine results in unnecessary medical expenditures which may also result in exposing patients to unnecessary danger from the tests. According to Feldstein (2007) physicians are able to shift the costs for these unnecessary procedures on to others including the patient or an insurance company. Feldstein (2007) also argues that if physicians are reimbursed on a fee for service basis they also benefit economically by prescribing additional testing for their patients. These tests, although desired by patients, usually provide very little if any benefit for the patient while protecting the physician from expensive law suits.

Sloan & Kasper (2008) argue that Tort Law should provide many functions including the provision of beneficial care, avoiding medical error and avoid wasteful care. It seems odd that fear of malpractice suits is actually causing the things that it was designed to prevent. By ordering more tests that increase the costs of health care, improves the provider's income by providing unnecessary care, and potentially providing the opportunity for increased medical errors that may result in harm or death to the patient.

DEMAND FOR PHYSICIAN SERVICES

The demand for physician services is what economists call a derived demand. The demand is derived from your demand for good health. Despite doctors complaining about their loss of power to managed health care our medical care delivery system is still largely driven by physicians who still have the continuing incentive for over-use of scarce health care resources.

A PriceWaterhouseCoopers study conducted in 2006 found that physician services accounted for the largest share of healthcare spending (24 percent). A large portion of this physician cost is related to defensive medicine which imposes unnecessary medical costs and medical risks while producing very little value for the patient. Kessler & McCellan (1996) point out that fear of legal liability may act as the incentive for physicians to administer costly precautionary treatments that offer minimal medical benefit. The physician also increases his or her income through the use of

this defensive medicine. These additional tests of little value may also produce greater risks for patients.

The Institute of Medicine (1999) reports that as many as 98,000 patients die each year from preventable medical errors. In many instances physicians and hospitals are actually reimbursed for having the error and then reimbursed again for rectifying the error if the patient lived. These errors included diagnostic and treatment errors, surgical errors, drug errors, hospital acquired infections and delay in treatment to name a few. The number of medical errors can only increase with more testing and hospitalizations that result from defensive medicine.

THE ETHICAL IMPLICATIONS OF DEFENSIVE MEDICINE

The practice of defensive medicine in order to protect the physician from lawsuits also benefits the physician in terms of increasing the physician's income. Many medical tests and procedures have been interpreted as defensive medicine that is a response to the threat of law suits. Chen (2007) argues that these additional tests are also a result of the corruption of medical decision making to earn additional income. These practices then are not the result of an attempt to benefit the patient but are ordered primarily to protect the physician from malpractice suits and also to increase the physician's income.

According to Dyck (2010) management ethics is nothing more than an evaluation of moral standards and how these standards influence the managers action. The physician acts as the manager of a patient's health when he or she makes decisions concerning tests or procedures to improve the health of the patient.

According to Boatright (2007) in order to determine whether an act is right or wrong we need to utilize ethical theories that are capable of enabling us to think through ethical business issues. The use of the ethical theory of utilitarianism has special significance when dealing with business decisions in making choices that offer the greatest overall benefits. The best approach to evaluate the use of defensive medicine by physicians would utilize the mainstream moral point of view. This point of view draws heavily on consequentialist theory which relies heavily on the consequences of the action in determining what is ethical. This theory suggests that actions resulting in beneficial outcomes for the individual are deemed ethical. The most used consequentialist theory is utilitarianism espoused by Jeremy Bentham and John Stuart Mill. They believed that utilitarianism requires ethical managers to produce the greatest good for the greatest numbers of people. The manager ought to act to produce the best consequences possible for the largest number of people. This is hardly the case with a physician practicing defensive medicine.

The costs of medical malpractice include the insurance costs and the costs associated with defensive medicine Santere & Neun (2010) points out that physicians believe that they are encouraged by the threat of malpractice to over utilize medical services. These physicians also benefit financially by ordering these additional tests and procedures to protect themselves from law suits. The other side effect of ordering additional medical care is the very real possibility of hurting the patient through medical errors resulting from the additional care. This possibility of hurting their patients while protecting themselves and increasing their own income is clearly a violation of medical ethics thus making defensive medicine an unethical practice.

DISCUSSION

It has become very clear that medical malpractice liability law is not achieving its objectives of compensating patients who have been injured by negligence and stopping providers from practicing negligently. It is also evident that the fear of medical lawsuits have clearly changed physician practice patterns resulting in more testing and procedures that usually provide limited value while dramatically increasing the cost of health care delivery in this country.

Providers of health services are paid for the services they offer rather than for the outcome they produce. The practice of defensive medicine increases the number of services offered by providers usually offering very little improvement in health outcomes while providing some protection from malpractice for the providers that order the tests. This additional testing increases the physician's income but may also place his or her patient at additional risk for medical errors.

Defensive medicine offers the majority of patients very little value while possibly exposing these patients to additional medical risk. This fact will usually make defensive medicine an unethical practice.

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THE USE OF MARKETING TOOLS TO INCREASE THE USE OF COLORECTAL CANCER SCREENING IN LUZERNE COUNTY, PENNSYLVANIA

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ABSTRACT

Colorectal cancer, the second most common cause of cancer death in the United States, is preventable if detected at an early stage. A readily available screening test can prevent many cases of this cancer by identifying and removing pre-cancerous polyps. Unfortunately, the majority of eligible Americans are not screened.

The rate of colorectal cancer in Luzerne County, Pennsylvania is alarming, approximately 20% higher than the state average and nearly 40% higher than the national average. This study attempts to increase the screening rate and reduce the incidence of this disease through the use of marketing tools. These tools include: development of a target market, use of a marketing mix, SWOT analysis, and promotion and dissemination of the return on investment (ROI) with other employers in the County in order to enroll more businesses in this project.

This project initially involved two businesses in Luzerne County who agreed to aggressively market colorectal cancer screening program to their employees over age fifty. A marketing plan was developed to increase awareness of the need for the screening beginning at age fifty and the dangers of ignoring this very preventable cancer. The availability of the test and information about the test was made available to all employees on both companies web sites for a two week time period before the screening program was conducted.

INTRODUCTION

The American health care system was never designed to prevent illness and promote wellness. The system of health care delivery was built to fix health problems after they occurred. The patient or consumer of health care services was given a passive role in his or her health status. The physician who is more knowledgeable about the value of health services was given the role of deciding what was needed to keep patients healthy. The problem with this method of delivery of health care is that the patient has to know when to see the physician. This requires the patient to be educated about high-risk health behaviors and disease. Unfortunately, the patient is not prepared to assume this role specifically when it involves colorectal cancer.

According to the Centers for Disease Control and Prevention (2007) the only way to prevent chronic diseases and their complications is through health education programs designed to prevent high-risk health behaviors in individuals and communities. These educational programs are not hard to develop but offer tremendous challenges in program evaluation which is required to attract the necessary resources to improve health. There is a need for a different type of evaluation process for

health promotion programs whose goal is the reduction in their burden from chronic diseases in the country.

Luzerne County, Pennsylvania has one of the highest rates of colorectal cancer in Pennsylvania and it also has one of the lowest rates of screening for this preventable disease in the state. This problem resulted in the formation of the Luzerne County Colorectal Cancer Screening Task Force in late 2008. The American Cancer Society hired a program evaluation consultant to provide advice and consultation for this task force in October, 2009.

One of the first recommendations made by the consultant was to develop a mission statement for the new task force. After this task was completed the next step was to identify an approach to deal with the high incidence and prevalence of colorectal cancer in Luzerne County. The consultant suggested that the task force develop and implement a marketing approach to the problem of low screening rates for this very preventable form of cancer.

METHODOLOGY

This colorectal cancer education program utilized a marketing approach to increase the awareness of the need for screening for colorectal cancer in Luzerne County. Two businesses were chosen in Luzerne County to participate in this program which began in May 2009. The program was made available to all employees of these businesses.

This educational program was developed on a SharePoint site at a local College. It consisted of a pre test, a colorectal cancer educational program and a post test of knowledge gained from the education program. The educational program consisted of a series of voice-narrated power point slides about the risk factors for developing colorectal cancer, the various tests available for this disease and recommendations for those at high-risk for developing this disease.

The program began with a pre test consisted of a series of questions about the epidemiology of colorectal cancer, the testing procedure, those at high-risk of developing the disease and a testimonial from a colorectal cancer survivor. The pre test is followed by the eleven minute educational program and then followed by a post test offering participants the same questions in order to determine if the educational program was successful in the educational process.

RESULTS

Completion of the First Educational Program

The first colorectal educational program was completed during May, 2009. There were 504 employees that were eligible to take advantage of this educational program and incentives were offered by the employer to encourage employees to complete the program.

The program consisted of a pre test (questions concerning colorectal cancer), an eleven minute voice-narrated colorectal cancer educational program and a post test evaluation of the knowledge gained by the educational program. There were 184 employees that participated in the program representing 36.5 percent of those eligible to attend.

Information concerning the availability of the program was sent by email and letter to all employees on two separate occasions. An incentive was offered to program participants for attendance ($10 Barnes Noble gift card or two free movie tickets). There were 28 employees that indicated a willingness to receive a follow-up phone call from the American Cancer Society six months after program completion.

Table 1: Pre- and Post-test results for program 1 (n = 184)

Item	Pre-test score	Post-test score	Significant change (p<.05)
#1) You are at risk for CRC if… (% indicated "all of the above": age 50 or older, have had a colon/rectal polyp, family history of CRC)	76.6%	84.2%	Yes
#2) Signs and/or symptoms of CRC include… (% indicated "all of the above": change in bowel habits, rectal bleeding, unexplained weight loss)	85.3%	95.7%	Yes
#3) An effective screening method for CRC is… (% indicated Fecal Occult Blood Test)	58.0%	88.6%	Yes
#4) Have you ever been tested for CRC? (% indicated "yes") - control question	41.8%	43.5%	No
#5) I plan to ask my doctor to be screened for CRC (% indicated "very likely" or "definitely")	29.4%	39.1%	Yes
#6) I plan to share what I learned about CRC with friends & family (% indicated "very likely" or "definitely") - post-test only	n/a	66.8%	
Note: Statistically significant change was determined by a pairwise t-test (df = 183)			

The first three items above assess the subjects' knowledge regarding colorectal cancer (CRC). In all three items the subjects' knowledge of CRC significantly improved in the post-test compared to the pre-test. Item #4 was inserted in both the pre- and post-test to make sure the subjects were carefully reading the items. Since the pre- and post-tests were administered over a short time period, as expected, there was not a significant difference in scores on this item. Item #5 was used to see if the program may influence subjects' behavioral intentions in relation to CRC. As indicated above, a significantly higher percentage of subjects intend on getting screened for CRC as a result of the program. Moreover, item #6 pertains to another aspect of the subjects' behavior. The vast majority of the subjects clearly intend to share what they have learned with their family and friends. Only 1.6% of the subjects responded "no" to this item. Overall, these subjects learned key information on CRC and are likely to take action to help prevent or at least detect CRC in themselves and/or others they care about.

Program 2

The second colorectal educational program was completed during June and July, 2009. There were 298 employees that were eligible to take advantage of this educational program and incentives were offered to encourage employees to complete the program.

The program consisted of the same pre test as described in program 1 (questions concerning colorectal cancer), the same eleven minute voice-narrated colorectal cancer educational program and the same post test evaluation given in program 1 of the knowledge gained by the educational program. There were 51 employees that participated in the program representing 17.1 percent of those eligible to attend.

Information concerning the availability of the program was sent by email and letter to all employees on two separate occasions. An incentive was offered to program participants for attendance ($10 gas card). There were 13 employees that indicated a willingness to receive a follow-up phone call from the American Cancer Society six months after program completion.

Table 2: Pre- and Post-test results for program 2 (n = 51)

Item	Pre-test score	Post-test score	Significant change (p<.05)
#1) You are at risk for CRC if… (% indicated "all of the above": age 50 or older, have had a colon/rectal polyp, family history of CRC)	78.4%	82.4%	No
#2) Signs and/or symptoms of CRC include… (% indicated "all of the above": change in bowel habits, rectal bleeding, unexplained weight loss)	94.1%	98.0%	No
#3) An effective screening method for CRC is… (% indicated Fecal Occult Blood Test)	76.0%	92.2%	Yes
#4) Have you ever been tested for CRC? (% indicated "yes") - control question	37.3%	39.2%	No
#5) I plan to ask my doctor to be screened for CRC (% indicated "very likely" or "definitely")	35.3%	51.0%	Yes
#6) I plan to share what I learned about CRC with friends & family (% indicated "very likely" or "definitely") - post-test only	n/a	72.6%	

Note: Statistically significant change was determined by a pairwise t-test (df = 50)

The results from this program were somewhat comparable to the findings from the first program. In all three knowledge questions, scores improved from the pre-test to the post-test. However, in only 1 item (#3) was this change statistically significant. One reason that significant changes were not found in two knowledge questions was due to the smaller sample size compared to program 1. Second, the subjects in program 2 had a much stronger knowledge of the signs and symptoms of CRC prior to the educational program. Thus, there was very little room for improvement. Similar to program 1, as expected these subjects did not indicate a change in prior testing of CRC. Moreover, these subjects are also more willing to be screened for CRC after the program as compared to before the program. Furthermore, a very large percentage of this group plans on sharing this CRC information with their loved ones.

In conclusion, both groups gained valuable knowledge from this educational program on CRC. In addition, both groups appear to have intentions to help prevent or detect CRC in themselves and their significant others. Thus, the program had value to meet this important health promotion objective.

DISCUSSION

Colorectal cancer screening is a very cost effective preventive program that is being used by far too few individuals even though it is available and paid for by most health insurance programs. Recent research clearly indicates that colorectal cancer screening is a missed opportunity that will save many lives and result in a reduction in the costs associated with this very expensive and deadly form of cancer.

The results from this colorectal education program offers strong support for the accomplishment of the goals put forth in the original mission statement of the Luzerne County Colorectal Task Force. For example, a significantly higher percentage of the employees in Program 1 and Program 2 are more likely to ask their doctor to be screened for colorectal cancer on the post test than on the pre test. This is very important because this represents the desired outcome from the program. All of the participants of both programs indicated that they are likely to share what they learned from the program with friends and family members. This was also very important because it was also the intent of the program.

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THE AMBIVALENCE BETWEEN CONTROL AND MANAGEMENT BY PHYSICIANS: AN OVERVIEW FROM HOSPITAL BOARDROOM

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ABSTRACT

To date, more attention has been paid to the one-tier system than to the two-tier one, in studying the relationship between hospital and physicians within the governance arena. We aim to highlight their contribution in either the supervisory board or management board role performance via the board process and using integration perspective. Based on the French hospitals case, we suggest a theoretical background for future empirical research.

Keywords: dual board, physicians, integration, board process

THE FORMATION OF A COMMUNITY PARTNERSHIP TO PREPARE FOR H1N1

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ABSTRACT

Health Education and Health Promotion programs are capable of reducing the incidence of epidemics of communicable diseases like influenza. According to the Centers for Disease Control and Prevention (CDC) (2009), health risk communication strategies are very important in the protection of the population in the event of pandemic influenza. Community partnerships can be utilized to develop health communication programs that can rapidly share vital information to large segments of the population. Vaughan and Tinker (2009) point out that health communication programs can also help the public to become an effective partner by fostering prevention activities and helping them to respond to the changing nature of a communicable disease pandemic.

One way in which information can be shared in rapid fashion with larger segments of the population is through the use if the internet. This information can be delivered by community agencies, especially at the local level, that include preventive services and educational programs to prevent diseases and their complications. One such program was developed through a partnership that involved the American Red Cross, a City Health Department and a graduate program in health care administration at a local college.

This program involved the development of a voice-narrated power point slide presentation about how to prevent infection with H1N1. This presentation also included a short pre-test and was followed by a post-test to determine the effectiveness of this program. The program was launched on the Health Care Administration program and was made available to all residents of Northeastern Pennsylvania. The program was marketed to the community by the partner agencies.

IN A NICHE OF TIME: THE NICHE APPROACH TO HEALTHCARE DELIVERY

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EXECUTIVE SUMMARY

OBJECTIVE

Niche hospitals represent a growing segment in the health care industry. A niche strategy is an approach that focuses on a narrow market segment that its resources and capabilities can exploit (Porter, 1980; Powers and Khan, 2004). The purpose of the proposed study was to provide an understanding of the antecedents and consequences of the niche approach to healthcare delivery. The interaction of the niche strategy and the physician-owner as a unique bundle of resources was also examined. The subsequent model tested the relationships among generic strategies, market effects, firm effects, and financial performance.

RESEARCH DESIGN AND METHODS

The evaluation of the Porterian focused differentiation strategy, also referred to as the niche approach to healthcare delivery, revealed efficient models that explain financial performance. The evaluation of the fully specified model suggested the use of Hierarchical Least Squares Regression as it was desirable to confirm the hypotheses about the potential relationships among the variables in the model. The full model consisted of one continuous dependent variable, five independent variables representing the market effects, and seven independent variables representing firm level effects. One way Analysis of Variance (ANOVA) was used to assess the differences in variation between specialty and traditional acute care hospitals. Pearson correlations were calculated to assess the correlations between each of the factors in the study.

RESULTS

The years of certification and occupancy percentage are statistically significant in the Porterian model. Ten percent increases in occupancy rates would provide a 22 percent increase in the dependent variable, ROA. The Porterian focused-differentiation variable was statistically significant and a 10 percent increase of this variable was found to contribute to a 15 percent increase in ROA. The Adjusted R-squared for the model was 8.1. While two of the firm level variables were found to be statistically significant, none of the market level variables were found to be significant.

CONCLUSIONS

The niche or focused factory strategy, as applied to healthcare, provides increased focus and efficiencies through repetition. Porter's (1980) framework can help hospital decision makers understand the dynamic nature of market forces, how these forces affect the strategic approaches of competitors, and how the interaction of these forces impact the financial performance of the firm.

A REVIEW OF THE MAGNET HOSPITAL CONCEPT FROM THE PERSPECTIVE OF ORGANIZATIONAL BEHAVIOR

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ABSTRACT

The U.S. health care system continues to be plagued by recurrent shortages of Registered Nurses (RNs). A promising institutional response to these shortages is a set of organizational practices collectively known as the magnet hospital concept. These practices are intended to enhance recruitment and retention of RNs by health care organizations. The magnet concept has received substantial scholarly investigation by nursing researchers over the past two and a half decades. Magnet research has verified a number of beneficial outcomes for patients, hospitals and nurses. This paper reviews the magnet literature to identify what has been learned about the magnet concept from an organizational behavior perspective. Overall, it is concluded that a substantial amount of behavioral research is still needed to better understand magnet organizations. While nursing researchers have made a commendable beginning on this research, it is recommended that organizational behavior scholars begin investigating magnet organizations to extend the breadth and depth of this research stream in the future. Specific research needs, at multiple organizational levels, are identified.

INTRODUCTION

The health care delivery system in the United States continues to be challenged by recurring shortages of Registered Nurses (RNs) (Kimball & O'Neil, 2002; Feldstein, 1999). Responses have emerged at both the systemic and institutional levels of society to address these shortages. At the systemic level, various interest groups representing nursing practice, education, employers, payers, and other stakeholders have advocated and pursued public policy and private sector initiatives (Feldstein, 1996). At the institutional level, health services providers, who are the primary employers of RNs, have undertaken various initiatives to address shortages in their local labor markets and specific to their organizations (AHA, 2002). Out of this diversity of initiatives a number of novel approaches have arisen that have achieved varying levels of acceptance and success (Kimball & O'Neil, 2002).

Over the last twenty years the magnet hospital concept has emerged as a potent intervention for addressing the nursing shortage at both the systemic and institutional levels. The magnet concept has been widely advocated by the nursing profession, adopted by leading institutions, and developed significant empirical research supporting its effectiveness (McClure & Hinshaw, 2002). The magnet concept is a specific set of organizational practices implemented by a health services provider in order to enhance retention of existing RN staff and achieve preferential hiring from the labor market

(McClure & Hinshaw, 2002). Beyond workforce advantages, a number of additional benefits have been identified as flowing from the magnet concept.

The purpose of this paper is to examine the magnet hospital concept from the standpoint of organizational behavior to determine the current state of organizational knowledge about this approach and identify future directions for research. The magnet concept is a set of organizational practices implemented by a health care organization that are intended to influence the behavior of RNs so that they choose to initiate and remain in an employment relationship with the health care organization. Understanding the behavioral antecedents and consequences of magnet practices would be useful in better explaining and predicting the impact of these practices in order to further develop the magnet concept and promote its beneficial adoption and diffusion in the health care system. This paper reviews a substantial body of research on the magnet concept over the last two decades to ascertain the extent of current knowledge about organizational behavior in magnet organizations and identify areas in need of further research

The approach taken in this paper is to briefly review the evolution of the magnet concept and then examine magnet related literature to identify research findings within the domain of organizational behavior. A brief review of the dimensions of the nursing shortage is provided first for contextual grounding. Next, a model providing an overview of the domain of organizational behavior is presented to serve as a guide in surveying in the magnet literature. The magnet literature is then reviewed to discern the breath and depth of investigation of organizational behavior related concepts. On the basis of this review, conclusions and recommendations for future research are presented.

FINDINGS AND RECOMMENDATIONS

As the number of ANCC magnet-designated facilities grows, they will provide an expanding base for future research on the magnet concept. A number of different directions for future research have been identified at the individual, group, and organization-wide levels for investigating organizational behavior in magnet organizations. This section summarizes findings from the review to present broad recommendations for future research related to the behavioral dimensions of magnet organizations.

Magnet research needs to be conducted in more diverse health care delivery settings in the future. Virtually all magnet research over the last twenty-five years has been conducted in acute care general hospitals. Since hospitals are the largest employer of the nursing workforce, this is understandable. However, nurses work in many other settings and changes in the health care delivery system indicate that there is a shift underway in the provision of care to ambulatory, long-term, and other non-acute settings. Potential areas for investigation in the future include applicability of magnet practices to other settings such as skilled nursing facilities, home care agencies, ambulatory diagnostic and treatment centers, and other non-acute organizations. Understanding if and how magnet concepts apply in these settings could be of great utility in the future given current trends in health care delivery.

Somewhat related to this extension of the magnet concept to new care delivery settings is the need to investigate the applicability of the magnet concept in international settings. Most industrialized countries are experiencing shortages of nurses and facing forecasts of greater

shortages in the future. Aiken and her colleagues have begun such an investigation in a five country study (Aiken & Sochalski, 1997; McKee, Aiken, Rafferty, & Sochalski, 1998; Sochalski & Aiken, 1999; Sochalski et al., 1998). Also, ANCC designation of the first magnet hospital in Great Britain marks internationalization of the magnet concept (Duffin, 2001) which has now extent magnet recognition to some five countries (ANCC, 2009). Substantially more research is needed in this area. Such research will provide an opportunity for understanding the importance of national culture and its impact on magnet principles. This research could be useful in better understanding the role of culture in U.S. health care organizations and in understanding the utility of the magnet concept in coping with an international nursing shortage.

To date the magnet concept has only been researched in regard to the nursing workforce. However, workforce shortages exist in other allied health professions such as Certified Registered Nurse Anesthetists (CRNAs), imaging professionals, pharmacists, and certain laboratory occupations (AHA, 2001). Also, health care delivery is becoming more multidisciplinary requiring higher levels of professional collaboration. For these reasons, investigation of extension of the magnet concept to other professional disciplines and to multidisciplinary teams is needed.

Substantial future research is needed in the area of organizational outcomes of magnet status. To date research on outcomes has primarily concentrated on turnover and satisfaction, however this research has been of questionable rigor. Both of these outcomes merit additional research such as studying other withdrawal behaviors that might be precursors of turnover (e.g., absenteeism, tardiness, disruptive behavior) and multiple dimensions of satisfaction of nursing and non-nursing staff. The outcome of productivity has also received amazingly limited investigation in light of its importance given current demands on health care organizations. Objective input-output measures are needed in addition to more sophisticated financial analysis of the cost-benefit of a magnet strategy. No empirical research on organizational citizenship behaviors has been reported. Continued diffusion of the magnet concept depends on being able to clearly demonstrate beneficial organizational outcomes in addition to those related to patient care. Such outcomes research needs to be a high priority for future scholarship.

Throughout this paper numerous areas for additional research at all organizational levels have been identified after examining available research. At the individual level, there are unique characteristics of the nursing workforce that make investigation of biographical related characteristics worthy of further investigation. In addition, areas such as personality, values, perceptions and related topics would be useful in understanding how individuals in magnet facilities may differ from those in non-magnet facilities. At the group level, there is a particular need for research on leadership in magnet organizations at all levels of the leadership hierarchy, given its apparent importance in adoption and implementation of magnet practices. Investigation of policies and practices is particularly needed at the organization-wide level, particularly human resource practices (e.g., High Performance Work Systems) and other practices that impact organizational culture.

There is a compelling need for organizational researchers to embrace the study of magnet organizations. To date, virtually all published research on the magnet concept in general, and magnet organizations in particular, have been conducted by nursing researchers. These scholars should be commended for their path-breaking work in this research domain. While their primary interest began with patient and nurse outcomes, they have extended this research domain to include

other organizational phenomena described in this paper. However, there is a now a need for organizational researchers from other disciplines to build on these foundations in terms of the breath of organizational phenomena investigated and in terms of the depth and sophistication of these investigations.

It is obvious from review of the magnet literature that magnet status in not a destination, but a continuing journey. Magnet facilities must continuously cope with the challenges required to sustain these practices and adapt them to a dynamic environment. Continued scholarship in this area will aid in better understanding the "behavior" of magnetism and harnessing it to benefit health care delivery in the future.

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CUSTOMER SERVICE AND EMPLOYEE TRAINING IN HEALTHCARE

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ABSTRACT

Customer service is a very significant element in the relationship building process between a customer and a company. It is very imperative that customers feel satisfied with their experience before, during, and after a transaction; this will lead to repeat business and ultimately loyalty. Throughout this paper the importance of clearly understanding a company's goal with respect to its customers, understanding the type of individual required to achieve such goals, and the value of appropriately strategizing from the Human Resource standpoint will be explored. Perhaps a great focus should be placed on the human resource department itself since that is the starting point of the customer value adding chain, the end point being the contact made through customer service. Human capital is an extremely valuable asset for a customer service driven company, therefore the skill of hiring and placing the right individual in the right position should be a top priority. Once the right individual is found another challenge/opportunity must be undertaken, that is the training process and knowing how to cultivate a positive and innovating workplace environment and culture. Satisfied and productive employees translate into consistent positive customer service engagements. Satisfied customers translate into increased profitability, meaning the bottom line is met.

INTRODUCTION/CONCLUSIONS

Future research is suggested based upon prior research and theory (Buckley and associates, 1992- present; Carland and associates 1984-present). Full paper available from first author.

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INFLUENCES OF HOSPITAL STRUCTURE ON MEDICAL MALPRACTICE CLAIM COSTS

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ABSTRACT

Malpractice is a significant concern in the provision of health care and can be an important performance measure for health care management. Utilizing the resource-based view of the firm, this study examines structural factors affecting the total amount of malpractice claims costs by hospitals in Florida in the year 2000. We found that hospitals employing a greater number of physicians had lower medical malpractice claims costs; however, hospitals employing a greater number of physician residents had higher medical malpractice claims costs. Interestingly, our study found that the number of employed nurses did not affect the medical malpractice claims costs of the hospital.