

IN THE MATTER OF ARBITRATION BETWEEN

SAINT FRANCIS REGIONAL MEDICAL CENTER)
"Employer")
AND) Kimberly Nordby, Grievant
SEIU HEALTHCARE MINNESOTA) FMCS No. 090928-61307-3
"Union")

NAME OF ARBITRATOR: John J. Flagler

DATE AND PLACE OF HEARING: January 5, 2010; St. Paul, MN

DATE OF RECEIPT OF POST-HEARING BRIEFS: March 29, 2010

APPEARANCES

FOR THE EMPLOYER: Noah G. Lipschultz
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THE ISSUE

Was there just cause for the discharge of Grievant Kimberly Nordby? If not, what shall be the remedy?

If not, what remedy applies.

BACKGROUND

Grievant Kim Nordby was terminated on the charge that she forged a hospital patient's daughter's initials on a mandatory Medicare form. Her actions might have gone unnoticed, but when the patient's daughter reviewed the form two days later when going over discharge paperwork, she advised Care Management Specialist Candace Lano that the initials were not hers.

The Grievant was responsible for the registration of the patient and she wrote the word "daughter" next to the initials on the Medicare form. She denies that she had placed the initials on the form. A comparison of documents bearing the daughter's actual initials and signatures on the form shows that the handwriting does not appear to match. The Union does not claim that anyone other than the Grievant handled the form. The Hospital credited the patient's daughter's word over the Grievant's based on the perceived lack of any motive for the daughter to deny her handwriting on the form and of certain prior misconduct including allegations of carelessness with respect to registration paperwork accuracy. The patient's daughter was not called as a witness.

Following the investigation the Hospital terminated the Grievant's employment on February 5, 2009.

RELEVANT CBA TERMS AND POLICIES

St. Francis Regional Medical Center (the "Employer" or "Hospital") is part of the Allina Hospitals and Clinics system of healthcare facilities. Allina and SEIU Healthcare Minnesota (the "Union") are parties to a collective bargaining agreement which covers certain employees at St. Francis Regional Medical Center. The CBA gives the Hospital the right to "discharge or discipline for just cause," and to "require observance of reasonable Hospital rules and regulations."

The CBA's arbitration provision provides that the Arbitrator shall not have the "authority to add, subtract, or modify the terms and provisions of this agreement."

The Hospital and the Union utilize a Corrective Action Procedure to address employee performance and behavior issues. That policy provides for termination "for more serious performance, conduct, or policy issues..." A Letter of Understanding between the Union and Hospital that implemented the Procedure expressly states:

Neither this Letter of Understanding nor the Corrective Action Policy will limit Allina's right to discharge or otherwise discipline an employee for a single serious offense or repeated offenses, or to withhold employees from service with or without pay pending an Allina investigation.

POSITION OF THE EMPLOYER

Falsifying a Medicare document is one type of offense that the Hospital views as warranting immediate termination in accordance with the Corrective Action Procedure. Grievant admitted she is aware that falsification of any document is prohibited and that the Hospital has strict policies concerning the accurate completion of Medicare forms and other patient-related paperwork. Patient Registration Specialists such as the Grievant are properly trained on Medicare procedures.

The document in question in this case is a Federally-mandated document called “An Important Message From Medicare About Your Rights.” The Hospital is required to provide the document to Medicare-eligible in-patients (or their family members) to advise them of their right to appeal their discharge from the Hospital. The Hospital is required to provide the document to the patient, or patient’s representative within two calendar days of admission.

The patient or authorized representative’s signature on the “Important Message” document is how the Hospital shows Medicare that it has complied with the regulations. Medicare’s guidelines specifically outline who is a proper representative to execute such document in the event the patient is unable. An employee of the Hospital or other healthcare provider is not authorized under the regulations to sign on the patient’s behalf because it would be seen as a conflict of interest. The Hospital can be subject to fines and other penalties for fraudulent signing of a Medicare document. The Hospital holds staff meetings with registration specialists and e-mail communications emphasizing that it is against the rules to sign or initial a patient’s name on that of a representative on the “Important Message” form.

If the registration specialist cannot get the “Important Message” form signed upon intake to the emergency room by the patient or a proper representative, then the patient registration specialist would need to pay a visit at a later time to the patient while on the hospital floor, after leaving the emergency department.

Grievant was hired as a patient registration specialist in May of 2002 and worked in that role until her termination on February 5, 2009. As one of 25 patient registration specialists, Grievant’s job duties included registering patients, processing intake paperwork, insurance forms, Medicare forms, authorizations for treatment, and similar paperwork.

On July 25, 2008, the Grievant received a verbal warning for inappropriate behavior toward her supervisor. On that occasion, Grievant’s supervisor Carruth was “rounding,” which is a routine one-on-one communication where the supervisor asks questions and provides the employee an opportunity to discuss any concerns. When Carruth attempted to engage in this dialogue, the Grievant allegedly became combative and yelled and raised her voice in front of other employees, in a public area. On September 22, 2008, the Grievant was counseled for failing to meet accuracy standards with respect to registration paperwork. On November 7, 2008, the Grievant received a disciplinary warning for failing to meet accuracy standards. Then, on December 12, 2008, the Grievant was again counseled for inappropriate behavior, in which the confronted co-worker was using obscenities after the co-worker pointed out errors in the Grievant’s paperwork. The Grievant admitted her conduct as described in the disciplinary notice

but claimed her behavior was not inappropriate because she “was on break and not out at the front desk.”

In a prior grievance meeting concerning performance-related discipline, the Grievant attempted to shift the blame for her deficiencies, and denied receiving training when the documented evidence showed otherwise. At the hearing the Grievant could not recall whether she made such a denial.

On Friday, January 23, 2009, Care Management Specialist Candace Lano was meeting with a patient and her daughter, Faith King, to go over the patient’s discharge plan. Lano provided King with a copy of the “Important Message from Medicare” she had received on January 21, 2009, upon her mother’s admission. Ms. King denied that she had signed or initialed the form. In fact, King was not even with her mother at the time of admission, so she could not have signed it at that time. Furthermore, she denied to Lano that she had signed or initialed the form at any point thereafter. She was so adamant that she demonstrated for Lano how she actually signed her name. Lano provided her with a new form (since it was still within the 48 hour admission window, in which the form is required) and had her execute that form. Lano proceeded to contact the Patient Registration Manager Carruth to investigate the situation. Lano had no idea who might have been responsible for the form in question and had never met the Grievant.

On Monday, January 26, 2009, Registration Manager Carruth discussed the incident with Lano and asked her to document King’s complaint. Carruth’s review showed that the Grievant handled the patient’s intake and the form in question and further that she had entered a note in the registration system on January 21, 2009 at 2:57 p.m. indicating that that the patient’s daughter had initialed the registration form.

Human Resources Generalist Anita Nystrom and Carruth then met with the Grievant and her union representatives on January 28, 2009. They showed the Grievant the January 21, 2009 form in question, the account history notes, and the form the patient’s daughter subsequently executed on January 23, 2009. The Grievant initially could not recall the patient or the daughter, but later recalled that she wrote the word “daughter” on the January 21st form, but denied placing the initials on it.

After the meeting, Nystrom had the “Important Message from Medicare” form for the same patient pulled from a visit several days earlier, January 17, 2009. A review of the patient’s daughter’s signatures on the January 17 and the January 23 forms showed that they were the same, and the January 21 form (which the daughter questioned) was different. Based on the comparison of the signatures, and the fact that the patient’s daughter was adamant that the signature on the 21st was not hers, the Hospital concluded that the Grievant, and not the daughter, had initialed the January 21st form.

Nystrom and Carruth’s assessment of Grievant’s credibility was affected by prior incidents in which she had acted in a manner interpreted as untruthful. In addition, through the offense of falsification of a government-mandated document was sufficient by itself to warrant

termination, a review of the Grievant's prior record revealed a number of disciplinary actions the Hospital deemed not to support mitigation of the penalty.

The truth test under a contract is whether a reasonable person, taking into account all relevant circumstances, would find sufficient justification in the conduct of the employee to warrant discharge.

An employer's judgment taking into account all relevant circumstances, reason and fairness justify discharge, is not lightly overruled. When considering whether just cause existed for discharge, an employer's decision to discharge should not be disturbed or modified by the arbitrator absent proof of discrimination, mitigating factors, or unreasonable or arbitrator action. The Union offered no evidence of any differential treatment for similar forms of misconduct.

The Grievant was adequately trained on proper completion of patient registration paperwork generally, on Medicare procedures specifically, and knew it was against Hospital policy to falsify a document. She admitted it would be improper for her to put her initials on the Important Notice From Medicare document.

The Grievant was responsible for the form in question, dated January 21, 2009. She wrote the word "daughter" on the form, and logged the form on to the Hospital's system with an explanatory note indicating that the daughter had initialed the form. Neither the Union nor the Grievant contends that anyone other than the daughter is responsible for the initials, and thus the only question is whether the initials match the daughter's handwriting. The Hospital reviewed the handwriting on the challenged document, compared to ones the daughter had actually signed, and concluded the handwriting did not match. On both "Important Message From Medicare" forms (January 17, 2009 and January 23, 2009), the patient's daughter signed her full name, yet on the form in question, there are only initials, which do not match the daughter's handwriting. It supports the Hospital's conclusion that the same person who initialed the document also wrote "daughter" immediately next to it.

The Union introduced a "Registration/Admission Consent Form" completed by the daughter on a prior hospital visit. That document bears the daughter's initials in three different places (below "Important Information for Patients"). A comparison of those initials with the initials found on the document Grievant was alleged to have forged shows two different individuals were responsible for the initials.

The Union contended that its defense of the Grievant was handicapped by its "inability" to cross-examine the patient's daughter and claim not to have known the identity of the patient's daughter until just before the hearing. This claim is false because the Grievant knew the daughter's identity and the Union had opportunity to subpoena the daughter but chose not to. In the January 28, 2009 meeting with the Grievant and the Union, the Hospital presented the two Important Message From Medicare forms, bearing the patient's daughter's identity. In addition, the Hospital complied with a pre-arbitration subpoena by disclosing additional documents which identified the daughter. In short, the Union was in no way prevented from calling the patient's daughter as a witness.

The Hospital, on the other hand, has an incentive not to involve patients or family members in such matters. Arbitrators have recognized that, in cases involving customer or patient complaints, policy reasons dictate that they cannot be expected to become embroiled in a union/employer dispute. The Hospital should not have to entangle an innocent relative of a Hospital patient under the circumstances. Hospital witness Lano, herself a union member, testified credibly as to the daughter's complaint. The hearsay evidence should be accorded significant weight under these circumstances.

There is no reason the patient's daughter would lie and deny that her initials were on the Medicare form. Grievant, on the other hand, had every motive to lie about it. It has been held that "a grievant's testimony is less credible because of the personal interest in the outcome of the proceedings."

The Union claims that the Grievant had no motive to initial the paperwork, as there was no need to have the document signed immediately. That argument is irrelevant and untrue. It was a time-saver for the Grievant. Policy dictates that if she does not get a signature on the form in the emergency room, she has to go up to the inpatient floor and get it.

This is an employee who had been careless with other forms of paperwork, and had acted dishonestly in the past. She had attempted to elude responsibility for disciplinary action relating to registration paperwork accuracy by claiming a lack of training, when she documented evidence showed he had been trained.

Given this background, and the fact that the handwriting on the documents did not match, the Hospital reasonably credited the patient's daughter's version of events over the Grievant's denial.

Grievant was a 6-1/2 year employee with a number of disciplinary actions in her file. While the Hospital believes falsification of a Medicare document by itself warrants termination, the Hospital weighed the Grievant's prior unsatisfactory work record which should not serve to mitigate the penalty.

POSITION OF THE UNION

The Employer bears the burden of proof in establishing that there was just cause for discharge. Even when the contract itself is silent, employers nonetheless bear the burden of proof in discharge and discipline arbitrations.

Several factors are traditionally considered by arbitrators when determining whether just cause for discipline exists. These include, but are not limited to the following: (1) whether the employee could reasonably be expected to know her conduct would subject her to discipline?; (2) Was the alleged violation of the rule fully, fairly, and adequately investigated before the discharge?; (3) Did the investigation uncover substantial proof that the employee did in fact violate or disobey a rule, and (4) Was the termination reasonably related to the employees record

and the gravity of the alleged offense? *Enterprise Wire Co.*, LA 46 359 (Carroll Daugherty). The weight given to each of these factors varies with each individual case.

The Employer's decision to terminate the Grievant is not supported by just cause for the following reasons: (1) the Employer's investigation was limited in scope and failed to investigate this matter fully and fairly, (2) the investigation did not uncover any substantial proof of guilt, (3) the decision to terminate is not reasonably related to the gravity of the alleged offense, and (4) the Employer failed to take into account mitigating factors as required by the applicable discipline policy and the just cause standard.

The Grievant was unjustly terminated for doing what her job requires. She is now expected to disprove something the Employer was never able to prove, and was denied the right to ever face her accuser.

Neither the Grievant's supervisor or the HR Specialist spoke directly with the patient's daughter. Instead the Employer relies solely upon Lano's recollection of the daughter's concerns regarding the document in question. The Employer failed to do any follow up with the daughter to find out if any other factors may have played a role in the confusion over the document in question. In fact when the Grievant's supervisor was asked if she thought it was important that just a few days earlier the patient had been admitted to the hospital, she states that it was not relevant to their investigation that the patient was just admitted a short time earlier. Any reasonable minded person would think that such events occurring so close together would be a relevant factor in the circumstances of the case.

Carruth testified that she was also confused about when they looked at certain documents and which documents they reviewed and if it was prior to the termination or after the decision to terminate was made. She went on to testify that she was not sure when the other documents had been pulled and which copies were provided to the Union. It should be noted that the Union was only provided the two copies of the documents at the meeting on January 28th. The Employer failed to provide the Union with any other relevant documents, which seems to demonstrate a much greater similarity to the daughter's initials and handwriting on other hospital documents in which that they claimed they pulled to perform comparisons of the handwriting. In fact the Union had to make a second request to obtain Union Exhibit 5 as it was not provided in the initial subpoena request made to the Employer.

The testimony of Lano was that the patient was "medically complex." This could have been a factor in the confusion going on at the time. It is clear that there would have also been many issues that the daughter may have been concerned about with the Hospital in general regarding the discharge of her mother just a couple of days earlier and the need for her to now be readmitted by ambulance.

It is plausible that the daughter may have been angry with Lano's care plan since her mother had to be brought back just a few days after being discharged earlier and may have been looking for an excuse to vent about the discharge process.

The Employer failed to produce any evidence that would from beyond a preponderance of the evidence prove that the Grievant falsified the document in question. It makes no sense for the Grievant to do so. It was common practice for employees to leave such documents for the following shift to get signed if unable to get the appropriate signature during their normally scheduled shift. The Grievant acknowledges that she has gone through extensive training and understands what an acceptable practice is and who is allowed to sign such a document. Under cross examination by the Employer's council she was able to answer that she understands and has followed the proper procedures for obtaining such signatures on such a document and has never waived from her position that she got the signature appropriately from the daughter. The Employer never produced any evidence showing that she would have had any issues if such a document had been left for the following shift. There was no evidence that the Employer was able to produce that would match the initials on the document in question to the documents signed by the Grievant over her seven years of employment with the Hospital.

The Employer produced nothing more than hearsay statements of confused patient's daughter and alleged concerns she may have raised. The Employer failed to even obtain as much as a signed statement by the daughter or to have the daughter be willing to be called as a witness in the hearing. The Employer did such a poor investigation that their chief witness was unable to testify about the daughter's state of mind at the time, whether there were any language barriers between Lano and the daughter or other factors which ought to have been explored in a proper investigation.

Furthermore, it is widely accepted view among many arbitrators, that in order to uphold a discharge where the alleged misconduct involves actions which are alleged crimes, the company must prove the guilt of the Grievant beyond a reasonable doubt.

The purpose of the Allina/SEIU Corrective Action Policy is to "correct or improve job-related performance behavior as well as to improve organizational performance." The Corrective Action Policy is designed to require the employer to use a different approach to corrective action and to do a deeper more thorough investigation into the issue rather than rushing to build a case to justify termination. In accordance with the Corrective Action Policy, the Grievant should have had a reasonable opportunity to learn whether the daughter was just simply confused about which documents she may have signed or initialed. The Grievant had not been given a proper opportunity to defend herself since no one followed up with the daughter to see if any other factors may have added to the confusion over the document in question.

The Employer failed to follow the negotiated agreement between the parties in how corrective action is to be determined and the guidelines used to make that determination. The Employer admittedly did almost none of the agreed upon procedures in making their determination for termination. Instead, they ignored what they had agreed to follow and disregarded their own contractual obligations. The Grievant was never given an opportunity to face her accuser. These parties developed a specific and detailed corrective action plan which took the parties over a year to negotiate. The Union and its members have every expectation that management would follow the agreement which they both agreed to follow. The Hospital in this case has failed to do so.

Termination is not reasonably related to the Grievant's record or the gravity of the alleged offense. Just cause does not exist where the penalty is not reasonably related to the employee's record and the gravity of the alleged offense.

The Grievant had excellent work record with the Hospital until her run in with her supervisor in July of 2008. It was clear by the supervisor's testimony that she took the Grievant's act to refuse to round with her without a Shop Steward present as a personal attack. It was from this moment that her supervisor would place the Grievant under the spotlight and attempt to load her file with corrective actions notations. During her employment with the Hospital, the Grievant received no disciplinary actions until that event in July. Over six years of her career at the Hospital she was able to perform her job with no problems or concerns and then only after earning the ire of her supervisor in July of 2009 did she suddenly become the target of repeated criticisms.

It would be hard to conclude that a fairly long term employee would be willing to jeopardize her career by forging initials on what is in this routine document. By the Employer's own admission this document would have been meaningless as they were going to have to get a new signed document by the patient or someone else because of her length of stay.

The facts show that the Employer's own actions were a much greater breach of both federal and state law than those charged against the Grievant. The Employer violated HIPAA and State law when they provided the Union with the un-redacted copy of the patient's medical record. Not only did they do it early in the investigation but again prior to the hearing when the Union subpoenaed additional documents for the hearing. Every day, patients share highly personal, sensitive information with healthcare providers, like St. Francis Hospital, and they expect the provider to hold this information in confidence, and use it only for the purpose of providing care. In line with these expectations, state and federal lawmakers have passed legislation requiring healthcare providers to carefully guard such protected health information. The Minnesota Patient Bill of Rights provides for the confidentiality of medical records.

The document given to the Union was printed on January 29, 2009 a day after the Grievant had been suspended and so only management could have produced the documents in question which was un-redacted, and clearly management admitted to missing the redaction. Yet no termination or discipline had occurred for making such a serious offense.

When the Employer withheld the name of the daughter to both the Grievant and the Union, they in turn created a situation where the Union and the Grievant were not allowed to confront the Grievant's accuser prior to the arbitration hearing. The act placed the Union and the Grievant at a distinct disadvantage in being able to fairly meet the charges and to establish plausible explanation as to what may have been involved in the report of the daughter's accusations. The inability to have such an exchange and the ability to face the accuser are a violation of a Grievant's right to industrial due process. To make it even worse the Employer charged with conducting a fair and full investigation failed to even interview the daughter to determine if any explanatory circumstance may have existed.

The documents that were finally provided to the Union when enlarged to get a better view, show that similar styles of handwriting were used by the daughter in previous documents which is uncontested the daughter signed and initialed. Using Union Exhibits 5-7 we can see those similarities, which is the registration admissions consent form dated January 17, 2009. The daughter makes three initials under number 4 with the third one looking the almost identical to the initials on the document dated January 21, 2009. Ms. Wolf testified that as part of her job at the hospital and because of HIPAA concerns she frequently is required to compare signatures when patients make requests for medical information. When asked to review the documents for comparisons she testified that she would have felt confident that the same person who initialed the January 17, 2009 was the same person who initiated the January 21, 2009 document as well.

This document also tells us a few more things when looked at closely. One that when Lano said earlier in her testimony that the daughter stated she never uses initials. That would not be an accurate statement by the daughter as this document clearly shows that she has initialed other documents at the hospital. Second, the date of January 17, 2009 tell us that her other was admitted on the 17th and likely there until the 19th of January. Just two days later the daughter's mother was brought back by ambulance to the hospital on the 21st of January. At that time the daughter signed her name at the bottom showing again similarities to the initials on the document on the 21st. In particular with the way she does the K in King and the F in Faith should be noted. Additionally, the Grievant was not familiar with the daughter prior to this day and would not have even known her name. It would have been impossible for her to have guessed which initials to have put on the document and how to have the similarities to replicate the daughter's signature.

Important Message From Medicare, which the daughter also signed twice, indicates similarities to the initials on the January 21, 2009 document. It also shows how she may have signed that document without paying particularly close attention to what she was signing. She clearly signs the document twice, once in an area that is not even meant for a signature. This suggests that it would be easy for her to be confused and not remember every document she may have signed or initialed. It is also understandable how someone could have blended different events and situations and may not have had the clearest remembrance of which documents she had recently signed.

The Employer failed to establish through their limited investigation that the Grievant had engaged in any activity which was not consistent with the training and protocols of the department. The decision to discharge her is not reasonably related to the Grievant's work record and the gravity of the alleged offense.

DISCUSSION AND OPINION

The threshold issue here, raised by the Union, concerns the question of the applicable standard of proof under the facts of this case. The Union contends that, inasmuch as the Employer asserts the charge of forging initials of another on a Medicare document constitutes criminal misconduct, the standard of proof must be that of "proof beyond a reasonable doubt." This contention lacks merit.

Except for the rare outlier, the near consensus of arbitrators holds that the “without a reasonable doubt” does not apply in the arbitration forum. Instead, this most demanding quantum of proof is properly reserved to the courts of competent jurisdiction which have the power to incarcerate, suspend civil liberties, place on probation and impose other punitive penalties on those found guilty of criminal offenses.

While termination of employment constitutes a heavy burden on an employee found guilty of serious job related misconduct, arbitrators, of course, lack authority to impose any of the punitive measures reserved to the courts. Accordingly, well accepted principles of industrial justice favor a less demanding standard of proof in the arbitration of discharge disputes. As a general proposition, the common law of arbitration advises that the more serious the charge for which an employee is discharged the more substantial should be the burden of proof. The rationale for this rests on considerations including the relative difficulty of finding another job as a consequence of the reasons for the termination.

This concept of relating the penalty to the potential damage to the discharged employment reflects the basic principle of justice that the consequences should fit the offense. It follows from this truism that terminations for such reasons as unsatisfactory performance, unreliable attendance, or accident proneness do not necessarily impair employment prospects in jobs for which the person may be better suited. In such cases arbitrators commonly rely on such standards as the mere weight of the evidence or, at most, the preponderance of the evidence.

When the charges for which the employee was terminated involve elements of criminal intent or moral turpitude, however, employment prospects may be severely damaged. In the instant matter, any prospective employer of the Grievant in her chosen field of health care and education would be disinclined to say the least to offer her a job when it was learned that she had been fired for forging initials on a Medicare document. In plain truth, if sustained, this criminal act would be an obstacle to gaining employment even in menial jobs.

In such circumstances of substantially diminished employability the most common standard applied by arbitrators is that of proof by clear and convincing evidence. This standard as applied in arbitration means the evidence adduced at the hearing should be clear as to what it purports to show rather than ambiguous, vague, or equivocal as to meaning and, further, should be substantial and forceful towards establishing the conclusion it is presented to show.

It should be noted in this regard that the notion of a standard of proof in arbitration remains a matter of discretion among arbitrators, with no absolute or finite gradations of proof observable in published awards. The West Coast Tripartite Committee of union and management representatives meeting with National Academy Arbitrators has reasoned:

...an arbitrator may wish, on balance, to be more persuaded than not (“preponderance”) in many cases; pretty certain in some others (“clear and convincing”)...¹

¹ Quoted in Hill and Sinicropi *Evidence in Arbitration*, BNA Series on Arbitration, Washington, DC (1980).

In any event, elemental logic supports the arbitral principle that while proof beyond a reasonable doubt should remain the standard solely of criminal courts, serious charges involving grave consequences for a grievant necessarily carry a heavy burden of persuasion on an employer. With this well-settled principle of proof in mind, this review now turns to the evidence adduced at the hearing.

The Hospital's evidence in support of its discharge decision consists of the following:

- Hearsay remarks by the patient's daughter, Faith King, that the initials on the Important Message From Medicare About Your Rights" form were not hers.
- Testimony of Care Management Specialist Candace Lano about Ms. King's denial.
- Copies of Ms. King's writings and that appearing on the "Rights" form which she claimed not to be her's.
- Testimony of Supervisor Carruth in regard to Grievant's disciplinary record from July 25, 2008 until December 12, 2008.
- Testimony of Human Resources Generalist Anita Nystrom and Ms. Carruth describing Hospital's relevant training activities provided the Grievant and the steps taken to investigate the facts leading to the discharge decision.

Review

The parties early in the hearing began to dispute the absence of Ms. King whose challenge to the authorship to the writing on the "Rights" form triggered the chain of events leading to the termination of the Grievant's employment. The Union's objection asserts that the Hospital relied on patent hearsay as the key element in determining that Ms. King's allegations were credible and the Grievant's denials were not.

The Hospital contends that it disclosed Ms. King's identity to the Union and if it wished to cross examine her they could have secured a subpoena Ad Testificandum from the Arbitrator compelling her testimony. Further, the Hospital's credibility judgment relied more on comparison of the writings on the "Rights" document and, for the Grievant's, her disciplinary record than merely on Ms. King's accusation.

Analysis. The failure of the Hospital to call the "absent declarant" to testify under oath and be subject to cross examination makes her testimony hearsay – which, while admissible in arbitration, receives only such probative value as may flow from other forms of corroboration. Under the circumstances of this case, the only corroboration comes from the sworn testimony of Candace Lano. The only part of Lano's corroboration carrying any probative value is merely that the absent declaration claimed that she had not signed the Rights document. Additional information in regard to whether or not this feature may have upset Ms. King or whether signing a second copy satisfied her could not be established.

The Hospital's defense that it chose not to call Ms. King to testify because it did not wish to cause any ill will towards a client is an insult to the principle that a person charged with a dischargeable offense has an inherent right to face her accuser. I find that the possibility of a client being inconvenienced by being called to testify in a matter of a full and fair hearing should

be held by the Employer as more important than the contractual rights of the Grievant to be appalling.

It is not surprising that the Hospital's research could turn up some misguided arbitrators who support this bizarre notion that, unlike any other system of justice in the western world, employees can be fired on the word of persons who are spared testifying because of some employer's interest in client relations. Any arbitrator who holds such beliefs would probably have no problem with the Hospital's suggestion that it was the Union's burden to subpoena the absent declarant in order to prove the Grievant's innocence.

Arbitrators routinely admit hearsay in order to draw such logical inference from its circumstances as possible. From the sworn hearsay testimony of Candace Lano it can be safely inferred that Faith King probably did state that the writing on the Rights form was not her's – otherwise there would have been no purpose in launching the investigation including the interview questions put to the Grievant. Absent cross examination of Ms. King, however, Candace Lano's hearsay testimony cannot go further than reporting that Ms. King had raised a concern about the initials involved.

By contrast, the Hospital produced copies of Ms. King's signatures on the same type of Rights form from her visit on January 17, 2009 (Employer Exhibit 12) and another signed by her on January 23 (Employer Exhibit 1) which the Employer concluded were signed by the same person, the patient's daughter. The Hospital also presented the disputed January 21 form (Employer Exhibit 3) which the daughter challenged as not her's and which the Employer concluded was affixed by the Grievant.

The options as to who signed the January 21 document are the Grievant, Ms. King, or unknown third party. Nothing in this record suggests that this document ever passed through the hands of a third party. Ms. King can also be dismissed by a process of logical elimination. In the first instance the two other Rights forms indisputably signed by her differ in significant regard, notably by the fact that the forms are signed by her full name and the word daughter following indicating her relationship to the patient.

The document in question, however, shows only initials, rather than the name Faith King fully spelled out. As mentioned earlier, an exception to the hearsay shadow on Ms. Lano's testimony must be recognized, as it remains clear that the absent declarant certainly denied that she wrote the suspect initials on the disputed form – otherwise Ms. Lano would have had no reason to report the denial to Ms. Carruth. Finally, visual inspection of the initials strongly suggest that they do not match Ms. King's.

The finding that only the Grievant could have been the signer of those suspect initials leads this review back to evaluation of the charge that she violated Medicare rules (thereby subjecting the Hospital possible fines and other penalties by "fraudulent signing" of a Medicare document. By its conspicuous mention of the terms fraud and forgery in describing the Grievant's misconduct the Hospital goes well beyond merely alleging a work rule violation to assert charges of criminal intent and conduct.

The nature of such allegations of criminality requires that the legal definitions of fraud and forgery be applied, rather than some mere colloquial version of these terms, especially because the Grievant will forever be tarnished by the criminal implications of what these charges cover. Certainly, prospective employers would be reluctant to hire any one terminated for fraud and forgery.

Standard law dictionaries define the act of forgery, in relevant part, as:

...with purpose to defraud or injure anyone...the actor...makes any writing of another without his authority...so it purports to be the act of another who did not authorized such act...Model Penal Code § 224.

Case law citations in *Black's Law Dictionary*², state in every instance the forgery is completed as a criminal act only when the writings are meant to defraud or injure another, e.g.,

...with intent to prejudice, damage, or defraud another person.

**

...with a design to defraud any person or persons.

Turning now to the legal definition of fraud, as related to the facts of the instant matter, *Black's Law Dictionary* states:

...some deceitful practice or willful device, resorted to with intent to deprive another of his right or in some manner to do him injury.

Similarly, *Black's Law Dictionary* defines the term defraud as:

To make a misrepresentation...intending one to rely...in which such person does rely to his damage...To deprive of...any interest...or right by fraud, deceit, or artifice.³

Certainly, none of the facts or arguments presented by the Hospital to support the charges of fraud and forgery begin to meet the widely accepted meanings of these terms. Conspicuous by absence is any evidence that the Grievant formed the intent to defraud Ms. King or the patient of any right nor was any proof produced that Ms. King, the patient, the Hospital, or the Medicare agency suffered any harm or injury as a result of the Grievant's misconduct. These missing elements are essential to establishing that the Grievant's rule violation constituted fraud or deceit, as charged.

The Hospital may well claim that it has been harmed by the Grievant's misconduct because it "may be subject to fines or other adverse actions" as a result of her misrepresentation on a Medicare document. I take arbitral notice based on similar assertions by employers of potential fines from various federal agencies for a range of discrepancies on official documents ranging from mismatched social security numbers on earnings reports to unauthorized removal of materials tags on sofa materials. Not a single example of any government action has ever

² West Publishing, St. Paul (continuing).

³ Ibid.

been cited in any of these cases – except where there were fraudulent attempts to claim some benefit, monetary or otherwise, to which the reporting employer was not entitled. No such issue of false claim for some benefit exists in this case.

The issue goes beyond a simple matter of “no harm, no foul,” however. The proven charge against the Grievant’s misconduct consists of her continued performance failures in handling paperwork, the critical function for a patient registrar. In light of the fact that the Grievant satisfactorily performed her assigned duties for some six and a half years, without any disciplinary blemish on her employment record, it can be confidently assumed that she qualifies as a candidate for the parties’ Corrective Action Program (Union Exhibits 2 and 3) to restore her to her customary level of proficiency and good conduct.

The Corrective Action Program (CAP) Process Snapshot states:

The Corrective Action Procedure is used for resolving employee performance and/or behavior issues in a safe environment. It is a process in which an employee and manager work together to identify the root cause(s) of issues and correct or improve job-related performance and/or behavior. In addition, to illustrate the value Allina places on our employees, the corrective action approach provides employees reasonable opportunities to improve their performance whenever productivity, quality, efficiency or behavior is below an acceptable level and to improve performance and/or behavior issues before employment is endangered.

Obviously, the CAP is being employed as indicated by the disciplinary action forms presented into the hearing record. The process follows a progressive step escalation where if conduct and/or performance issues persist a stronger corrective action may be taken, as follows:

Section Name: Corrective Action Procedure

You as the manager/supervisor, in consultation with your HR Representative, determine the appropriate corrective action option, including whether the action is disciplinary or non-disciplinary.

The following list is a general description of the Corrective Action Procedure. You, in consultation with your HR Representative, have the right to skip any or all of the actions listed. (See “Just Cause” provision of the contract.)

- Non-Disciplinary Corrective Action
- Level 1 – Coaching – The Conversation
- Disciplinary Corrective Action
- Level 2 – Verbal Counsel
- Level 3 – Written Counsel
- Level 4 – Day of Decision
- Level 5 – Termination

*Any level (1-4) can be repeated one time prior to the time limit expiration (Level 1-3 = 6 months; Level 4 = 1 year)

The Hospital's brief asserts that the Grievant's disciplinary record from July 25, 2008 through her termination on February 5, 2009 consists of the following:

- Incident: July 25, 2008
Accused of being "combative" towards Supervisor Carruth when she attempted a "rounding" to discuss performance. Grievant testified that she merely requested that a union representative be present during the discussion.

Finding: The Hospital showed that Carruth issued the Grievant a "verbal warning." The matter was not timely grieved and cannot be reversed at this late date under the CAP, therefore, this incident represents a Level 2 Disciplinary Corrective Action.

- Incident: September 22, 2008
Charged with "Performance. Accuracy not meeting 90% expectation." The Hospital's brief asserts that the Grievant received "verbal counsel Level 2."

Finding: This is incorrect. The CAP form for this incident indicates "The Conversation – Level 1," a non-disciplinary corrective action. (Employer Exhibit 15)

- Incident: November 7, 2008
A second action in regard to "Performance – accuracy not meeting 90% expectation." The Hospital brief claims that the Grievant received a written warning for her unsatisfactory performance.

Finding: Again the brief is incorrect. The CAP form in evidence for this incident shows that the Grievant was issued a "Verbal Counsel Level 2" corrective disciplinary action.

- Incident: December 12, 2008
The Grievant was disciplined for a verbal confrontation with a co-worker where she allegedly used obscenities in a public area. She was issued a "Level 2 Verbal Counsel."

Finding: The Grievant claims the disciplinary action was unwarranted because it did not take place "on the floor or in any other public space." This defense lacks merit.

- Incident: January 21, 2009 and February 5, 2009
Terminated for "Falsification of a Medicare document...does not comply with hospital standards and is illegal."

Finding: The charge of illegality, i.e., forgery and fraud, has been addressed above and dismissed. All that remains to be reviewed is the matter of the Grievant's continuing performance problem plus what amounts to a major misconduct in violation of the Hospital's rule against unauthorized signing of an official document.

Union Exhibit 3 charts the CAP progression of disciplinary/corrective actions. There should be no serious question over the appropriate disciplinary step warranted by the Grievant's

uncorrected performance problem together with her gross misconduct of January 21, 2010. Those offenses call for the final step short of Termination – Level 4 Day of Decision. The CAP describes this step as follows:

The Day of Decision is utilized for more serious performance, conduct or policy issues or after exhausting all previous levels of the Corrective Action procedure. The Day of Decision is intended to be non-punitive and have no financial impact on the employee. The employee is to utilize this day as a time of reflection and choice. The employee has the opportunity to choose to change his/her performance and/or behavior and continue working, or to sever the employment relationship with Allina. If the employee decides to return to work, he/she will be required to assist in the development of and sign a Final Corrective Action Plan. If the employee decides to return to work but refuses to acknowledge the issue or if agreement on a Final Corrective Action Plan cannot be reached, the manager will prepare and implement the Plan and give a copy to the employee, SEIU and HR.

This review ought not close without consideration of the significance of the Grievant having achieved an unblemished employment record for six and a half out of her almost seven years of employment only two commit to performance failures, two misconduct incidents, and the one gross misconduct which resulted in the Hospital's termination decision all written less than five months. Such a precipitate fall in a conduct and performance less than five months after some eighty four months of discipline free service begs for an explanation of the searching sort promised by CAP in guiding management to:

- Determine the root caused of the issue.
- Seek creative and comprehensive solutions, which address all contributing factors; problem solve with the employee
- Consider tapping into other resources...Employee Assistance Program (EAP).
- Offer the Employee Assistance Program to the employee.

DECISION AND AWARD

On the basis of the foregoing findings and conclusions, the grievance is sustained to the extent that the penalty of termination is reduced to a Level 4 Decision Making Leave. The following actions shall be taken in connection to this reduction in penalty.

- The Grievant shall be immediately reinstated to her former position upon receipt of this Decision and Award.
- She will be placed on Decision Making Leave promptly after her return to work, pursuant to CAP.
- She will be compensated for all pay loss and benefits minus interim earnings.
- Consistent with CAP recommendations, the Grievant shall be referred to the parties' Employment Assistance Program. As a condition of continuing employment, the Grievant shall cooperate in whatever course of counseling and/or medical care prescribed by qualified health care professional she is referred to by EAP representatives, to the extent of her health insurance coverage.
- In the event the parties have no operative EAP in place, the Grievant shall report to a qualified health care professional jointly agreed upon by the Hospital, the Grievant, and the Union for evaluation.
- The Grievant shall cooperate in whatever counseling and/or health care treatment recommended but the professional evaluator to the extent covered by her health insurance.
- The Arbitrator retains jurisdiction in this case solely for the purpose of resolving any dispute over the Remedy herein directed.⁴

4/7/2010
Date

John J. Flagler, Arbitrator

⁴ The Hospital emphasizes that the CBA denies the Arbitrator authority to "add, subtract or modify terms and provisions of this agreement." Lest this provision seem in any way to limit or prohibit any part of the remedy thereafter directed, the parties are referred to the following U.S. Supreme Court opinion: "When an arbitrator is commissioned to interpret and apply the...agreement he is to bring to informed judgment to bear to reach a fair solution...This is especially true in formulating remedies. There the need is for flexibility in meeting a wide variety of situations." *Steelworkers v. Enterprise Wheel and Car*, 363 U.S. 593, 597 (1960).