

Cornell University

# HOW LABOR-MANAGEMENT PARTNERSHIPS IMPROVE PATIENT CARE, COST CONTROL, AND LABOR RELATIONS

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*Case Studies of Fletcher Allen Health Care, Kaiser Permanente, and  
Montefiore Medical Center*

*"No doubt that a small group of thoughtful citizens can change the world.  
Indeed, it's the only thing that ever has."  
Margaret Mead*

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## EXECUTIVE SUMMARY

In the wake of the Patient Protection and Affordable Care Act, which was signed into law in March 2010, many healthcare systems are developing innovative ways to improve the quality of the services they provide while simultaneously controlling costs. However, front-line staff—including nurses, physicians, residents, allied health professionals, social workers, environmental services workers, and clerical workers—are often excluded from the development of such initiatives.

Yet, the inclusion of front-line staff in quality improvement and cost containment work is crucial. They are often the employees with the most intimate knowledge regarding where everyday work processes break down, and they also tend to have the best handle on viable solutions. Furthermore, to effect change successfully in complex healthcare systems requires commitment and input from all organizational stakeholders. Labor-management partnerships offer precisely the type of framework needed, one that engages all staff in productive dialogue to restructure the way care is provided.

The Contact Center at Montefiore Medical Center's Care Management Corporation (CMO, The Care Management Company, New York City), Fletcher Allen Health Care (Vermont), and Kaiser Permanente's San Rafael and San Diego Medical Centers (California) have all introduced labor-management partnerships as a vehicle to improve the quality of clinical care and reduce costs, and also to create healthier workplaces for staff, strengthen teamwork, and improve labor relations.

The following case studies provide important data that show how healthcare labor-management partnerships are being created and sustained. This report offers only a snapshot of such activities. Further research is still needed to develop complete empirical data on the approaches used and outcomes that have been and can be achieved.

The case studies point to four general areas in which labor-management partnerships can lead to positive outcomes:

1. **Clinical Processes:** At Montefiore's Contact Center, Fletcher Allen, San Rafael, and San Diego, restructuring clinical processes to be more efficient, patient-centered, and cost-effective are central goals of their partnership work. Clinical process improvements at the four health systems have included:
  - A significant increase in the number of referred home care patients who are seen within 24 hours from 44 percent in January 2010 to 83 percent in November 2010 (Home Health Care, San Diego Medical Center).
  - A fall rate that decreased from 3.07 falls per 1,000 patient days in 2010 to 2 falls per 1,000 patient days in January and February 2011 (Baird 3 Surgical Unit, Fletcher Allen Health Care).

- Achievement of a 45-minute stroke alert test result turnaround time benchmark (Clinical Laboratory Services, San Rafael Medical Center).
2. **Workplace Environment:** An articulated partnership process creates an environment in which front-line staff and management feel comfortable working collaboratively to overcome roadblocks to effective communication and workplace safety, along with other challenges. This mutual understanding and trust fosters a more respectful workplace and a problem-solving process that includes all voices. Specific outcomes at the four medical centers include:
    - Zero reported workplace-related injuries in 2010 and just 2 in the first 5 months of 2011 (Clinical Laboratory Services, San Rafael Medical Center).
    - 450 overhead pages (announcements) per month reduced to 422 total pages *per year* (Operator Services, San Rafael Medical Center).
    - Introduction of multidisciplinary rounds (Inpatient Psychiatry, Fletcher Allen Health Care).
  3. **Labor Relations:** Labor-management partnerships help develop a new paradigm for interactions between management, front-line staff, and labor unions that is collaborative rather than adversarial. Improved labor relations are reflected in the following outcomes:
    - Creation of a non-punitive promotional strategy and career ladder (Montefiore's Contact Center,).
    - New nursing staffing ratios that were developed by nurses and nurse managers (Fletcher Allen Health Care).
    - Embracing partnership as "the way things work" at all levels of organization (Kaiser Permanente, San Rafael and San Diego Medical Centers).
  4. **Cost Savings:** An effective labor-management partnership can have a considerable impact on the expenditures of a single unit and the bottom line of an entire healthcare organization. Specific cost-savings that resulted from joint work processes include the following:
    - \$51,000 reduction in overtime wages (Operator Services, San Rafael Medical Center).
    - Reduced staff turnover rate from 14 percent in 2008 to 3.9 percent in 2010 (Montefiore's Contact Center,).
    - Reduced cost per communication contact from \$7.62 in 2004 to \$4.06 in 2010 (Montefiore's Contact Center,).
    - Reduced nursing staff turnover and traveling nurse hires (Fletcher Allen Health Care).

A synthesis of the lessons learned from the four case studies points to eight essential best practices that make possible the achievement of the positive outcomes discussed above. These include:

1. **Active Union and Management Leadership:** Active union and management leadership ensures that the partnership process has sufficient resources to be successful. Ideally, actively engaged leaders will monitor partnership activities so that changes are sustained and spread throughout the organization.
2. **Clear Partnership Structure:** A clear partnership structure allows the union and its members to have a direct role in decision-making, quality improvement, and work process redesign. A well-defined partnership structure also creates a formal process for supporting joint activities. A common practice is to have a steering committee or council made up of labor and management representatives who are responsible for overseeing partnership activities.
3. **Clear Union and Management Goals:** Both labor and management should develop clearly defined goals for what they hope to achieve through the partnership. These goals should include union-building initiatives as well as both unit-based and hospital-wide quality improvements to increase patient satisfaction while controlling costs.
4. **Institutional Support for Partnership:** Collective bargaining language is usually needed to articulate the goals of the partnership while specifying the roles and responsibilities of those involved in the joint work. Collective bargaining language should be flexible to reflect changes in the goals and structure of the partnership process as it evolves. In addition, both unions and management need to commit funds for resources such as internal and external consultants, coaches and educators for staff, and a budget to provide front-line staff sufficient time to work on partnership activities and to undergo training.
5. **Education:** Union members and managers should be introduced to the structure, purpose, and goals of the partnership by union and hospital leaders. These key stakeholders should also understand how providing high quality, patient-centered, and affordable healthcare can be achieved through the partnership approach. Labor-management partnership stakeholders should see their joint work process as an opportunity to restructure the delivery system in which they work and not as a stop-gap measure to allow broken systems to continue to function. Education and training should include methods for innovation as well as quality improvement tools.
6. **Communication and Accountability:** Because all staff members cannot always participate directly in partnership activities, there should be active communication between those who engage in joint work and those who do not. Tools such as communication trees, communication boards, e-mail, and huddles can be used to maintain a flow of information and obtain input from all staff.

7. **Monitoring and Tracking Results:** Keeping detailed records is critical for analyzing and quantifying the impact of joint activities. It is also important to track and share the successes of joint work with peers, patients, various stakeholders, external partners, and regulatory groups to document the achievements of the partnership process.
8. **Redesigned Labor Relations:** To create an environment that is respectful of the workforce and supportive of a partnership, labor relations need to be conducted in a problem-solving rather than adversarial manner.

The case studies of Montefiore's Contact Center, Fletcher Allen, San Rafael, and San Diego reveal that a strong union presence is important but not sufficient to make a significant impact on improving patient care. Rather, having a unionized workforce participate in a structured partnership process makes it possible to identify and sustain improvement activities and creates a collaborative work culture. For these arrangements to work, labor and management need to move beyond their traditional adversarial relations and develop appropriate methods to redesign and restructure healthcare systems. Partnerships, when effectively organized with appropriate resources, tap the expertise of both front-line staff and management to get results.

# INTRODUCTION

Signed into law in March of 2010, the Patient Protection and Affordable Care Act introduced healthcare reform initiatives designed to reduce healthcare disparities, lower costs, and regulate the practices of health insurance companies. Nevertheless, many hospitals and long-term care facilities still struggle to provide coordinated care services for their patients while keeping costs low and quality high. Underlying this struggle is a fragmented system faced with escalating budget reductions, limited resources, major changes in regulations, and increasing transparency of clinical and patient satisfaction outcomes. Furthermore, lack of patient access to preventive care and chronic disease management services, avoidable hospital readmissions, minimal patient engagement, and poor communication between caregivers, among other factors, contribute to the continued rise of the cost of care.

To address these issues will require multifaceted solutions that target the ways in which hospitals and other healthcare organizations provide and pay for services. To ensure that improvement efforts are effective and responsive to “on-the-ground” issues, it is imperative that front-line staff be engaged in reform initiatives. Healthcare unions must become drivers for change, taking a proactive role in improving the provision of care.

This paper explores the ways in which healthcare unions and their members are strategically engaging with management through partnerships to control costs and improve patient experiences, clinical outcomes, the workplace environment, and labor relations. These strategic initiatives depend on making use of the knowledge of front-line healthcare workers, improving communication between all staff members, and increasing transparency. In turn, such initiatives can lead to more robust and dynamic local unions. Unions can benefit by offering their members the ability to shape decisions about how work gets done, helping members feel more respected in their workplace and more connected to their union.

“Unions need to initiate and take the lead to improve the quality of care of patients and find ways to cut costs. Unions can’t allow themselves to be bystanders but instead must be champions for these changes.”

John August, Executive Director of the Coalition of Kaiser Permanente Unions  
“Why Unions Should Be Part of the Delivery System Changes,”  
Presentation May 2010.



## **Background of Labor-Management Partnerships**

Collaboration between labor and management to improve working conditions and quality of services has been an important theme within the labor movement since the early 1920s. The railroad industry was one of the first to pioneer partnership work in order to end violent conflicts between labor and management and to expand passenger service throughout the United States. During World War II, Walther Reuther, former President of the United Auto Workers (UAW), initiated joint projects with management and the federal government to improve productivity and workplace safety while actively advocating for the conversion of automobile manufacturing plants into factories that would produce tanks and airplanes for the Army, Navy, and Air Force.

After World War II, the majority of such activities moved overseas to Europe and Scandinavia where institutes were established to learn how to create effective labor-management partnerships. Since the 1980s, the United States has revisited its use of labor-management partnerships as a tool for improving services in some sectors of the economy. Union leaders such as Irving Bluestone and Donald Ephlin of the UAW, Lynn Williams of the United Steelworkers, Morty Bahr of the Communication Workers, and Jack Sheinkman of the Amalgamated and Textile Workers Unions have been at the forefront of establishing partnership activities, from the Tarrytown assembly plant of General Motors to the Saturn Corporation, Xerox, Hathaway Shirt Company, Hickey Freeman, Inland Steel, AT & T, Harley-Davidson, NUMMI, and Levi-Strauss.<sup>1</sup>

The adoption of the partnership approach has not been without controversy. Union leaders debate whether labor-management joint work undermines member support for the union and compromise union autonomy. This belies an ideological belief that the direction of production and quality improvement falls under the purview of management and not union members. Nevertheless, those unions that have chosen to pursue joint work with management feel working in partnership has engendered greater respect for workers, increased productivity, increased union density, and improved quality of work life. Rather than compromising the union, labor-management partnerships can actually expand the influence of the union and its members.

### *Labor-Management Partnerships in the Healthcare Industry*

Several significant labor-management partnerships have recently been tried in the healthcare industry. As will be discussed in the body of this paper, one of the most longstanding of these began at Kaiser Permanente, the largest health maintenance organization (HMO) in the United

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<sup>1</sup> There have been mixed outcomes related to the processes used and areas of focus. Eileen Appelbaum and Larry W. Hunter, *Union Participation in Strategic Decisions of Corporations* (Chicago: University of Chicago Press, 2004);

States. Peter diCicco, on staff at the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), and John Sweeney, past President of Service Employees International Union (SEIU), with a coalition of multiple unions representing Kaiser Permanente employees and the company's management pioneered a comprehensive partnership process in the late 1990s. This labor-management partnership continues to be at the foundation of how Kaiser Permanente operates and meets its organizational goals.

A partnership also took hold in New York in 1997. As a result of the creative leadership of Dennis Rivera, past President of 1199/SEIU (representing healthcare workers and retirees in New York, New Jersey, Maryland, the District of Columbia, Florida, and Massachusetts), and Bruce McIver, Executive Director of the New York League of Voluntary Hospitals and Homes—the bargaining unit for 109 non-profit medical centers, hospitals, and nursing homes in the greater New York metropolitan area—partnerships were established in nursing homes and hospitals covered by the League's collective bargaining agreements.<sup>2</sup> Similarly, partnerships have been established at Maimonides Medical Center in Brooklyn, New York; Los Angeles County's Medical Center; and Allegheny General Hospital in Pittsburgh, Pennsylvania.

Labor-management partnerships in healthcare facilities have required strong and progressive union and management leaders in order to launch and sustain support for joint work activities. Union leaders today face an additional challenge when considering establishing a labor-management partnership. Because union density is declining, there is considerable pressure for union leaders to focus their time and resources on activities that are explicitly “union building.”<sup>3</sup> In the context of healthcare in particular, improving quality of care and patient safety and reducing costs are important goals but not often priorities for senior union leaders. Therefore, for labor-management partnerships and quality improvement initiatives to be successful, union leaders must make a firm commitment to developing strategies to meld partnership and union-building work.<sup>4</sup>

### **The Four Case Studies**

As previously stated, this paper is divided into four case studies. The first two investigate San Rafael and San Diego Medical Centers, which belong to Kaiser Permanente's HMO. As with all

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<sup>2</sup> The New York League of Voluntary Hospitals and Homes is the bargaining unit for 109 non-profit medical centers, hospitals, and nursing homes in the greater New York metropolitan area, partnerships were established in nursing homes and hospitals covered by the League's collective bargaining agreements.

<sup>3</sup> 2010 Bureau of Labor statistics indicate that in healthcare less than 30% of workers are organized and union density is roughly 6.9 % in private sector jobs and 11.9% of total wage and salary earners in the United States are members of a union.

<sup>4</sup> Union-building outcomes include organizing new members (both internal and external organizing), more contact and engagement with members, greater contributions to political action campaigns, more active stewards, and more activists.

medical centers at Kaiser Permanente, these hospitals participate in a system-wide *labor-management partnership* (LMP) that was established in 1997 and involves 11 international unions as stakeholders. The case studies of San Rafael and San Diego focus specifically on the activities of the medical centers' *unit-based teams* (UBTs), the primary vehicle developed to advance the LMP's goal of providing high-quality, cost-effective, and patient-centered care in an exceptional work environment. To date, UBT activities, with strong support from both labor and management sponsors, have mobilized the insight and continuous innovation of front-line staff and managers to improve patient care, employee satisfaction, and communication across Kaiser Permanente.

The third case study profiles the *model unit process* (MUP) at Fletcher Allen Health Care in Burlington, VT. The MUP took root in 2005 after a contract dispute between the hospital and the then newly organized Vermont Federation of Nurses and Health Professionals (VFNHP Local 5221) around nursing staffing ratios. Rather than resolve the issue through arbitration, the union seized the opportunity to create a joint process that would not only reconfigure staffing ratios but also tackle quality of care, workplace environment issues, and communication. Driven by VFNHP, the MUP has had a significant impact on clinical outcomes, nursing staffing ratios, nurse and nurse manager communication, and nurse engagement at Fletcher Allen. This case study is a powerful testament to the ability of unions to bring management and hospital administrators to the table to carry out partnership work.

The final case study in this paper details an expansive project at Montefiore Medical Center in the borough of the Bronx, NY. Introduced by Montefiore in 1996, CMO, The Care Management Company (CMO) was designed to manage the coordination of comprehensive healthcare services for residents of New York City's poorest borough. Accordingly, CMO has worked to transform an outdated reimbursement system, establish partnerships between physicians and community groups, and develop an effective process to manage patient care. The description of CMO included in this report will describe the core elements of its mission and analyze the joint work underway at the Contact Center—the CMO department with the most developed labor-management partnership process.

The four healthcare systems profiled have achieved impressive clinical and workplace redesign outcomes through collaborative labor-management partnership processes. However, fostering partnership is not an easy task. For example, at Fletcher Allen, nurses and their union spearheaded the partnership initiative, but it has proven difficult to disseminate information and involve a significant number of nurses in joint work activities. Furthermore, the collaboration remains largely restricted to nurses and nurse managers and has not been expanded to include, physicians, specialists, environmental service workers and other front-line staff. Similarly uneven participation is evident within the Kaiser Permanente LMP system. At San Rafael Medical Center, nurses represented by the California Nurses Association (CNA) are absent from partnership activities, as their union is involved with neither the Coalition of Kaiser Permanente

Unions nor the labor-management partnership for political reasons. By contrast, at San Diego nurses represented by the United Nurses Associations of California (UNAC) are active participants in the coalition and partnership. Because of the diversity of partnership processes and experiences at each medical center, these case studies will pinpoint differences and challenges alongside the specific approaches used to achieve results.

Comparative analysis of San Rafael, San Diego, Fletcher Allen, and Montefiore's Contact Center reveals that the involvement of healthcare unions, including both leaders and members, in restructuring initiatives affecting the entire delivery system yields concrete clinical improvements. Further, such improvements are directly linked to increased involvement of front-line healthcare workers in the process. However, union presence and proactive union leadership alone is not sufficient to generate the outcomes achieved at the four medical centers discussed in this paper. To be truly effective, a clear partnership process should combine with education, training, and access to information for staff and management alike. With all these elements in place, front-line staff have a solid foundation from which to participate in sustained problem-solving initiatives. It is this combination of union participation and defined partnership structures that creates a context in which substantial improvements in patient care, cost reduction, and quality of work life can be achieved.

## **KAISER PERMANENTE: LABOR-MANAGEMENT PARTNERSHIP**

### **Overview**

Kaiser Permanente is the largest not-for-profit HMO in the United States, serving nine states and the District of Columbia. The Kaiser Permanente system provides care for nearly 9 million members and employs 15,129 physicians and 164,098 healthcare workers. Over 120,000 of these workers belong to a labor union. The Coalition of Kaiser Permanente Unions represents more than 93,000 unionized employees within the organization.

Negotiations to establish a Labor-Management Partnership (LMP) began in 1995 in response to the unrest generated by financial pressures during the 1980s and early 1990s. The proliferation of for-profit healthcare providers, the expansion of Kaiser Permanente services across the country, and a growth strategy based on lowering prices without increasing internal capacity to care for new patients led to declining market share, closure of facilities, layoffs, concession bargaining, and diminished quality of care.<sup>5</sup> This state of affairs, in turn, caused deep dissatisfaction among the members of the twenty-seven local unions that constitute the Coalition of Kaiser Permanente Unions. The Coalition responded with the threat of strikes and an all-out corporate campaign.

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<sup>5</sup> Kochan (2009), p. 24-5.

After much deliberation, the LMP was approved by a 90 percent majority of affected Kaiser Permanente workers in 1997.<sup>6</sup> The LMP's Founding Agreement, composed that same year, laid out the mutual goals of Kaiser Permanente and the union coalition: improving labor-management relations, augmenting quality of care and patient satisfaction, and increasing Kaiser Permanente's market share while providing job security for its employees.

The current governance structure of the LMP is complex and includes representation from both labor and management stakeholders at every level. The ultimate governing body of the LMP is the Labor Management Strategy group (LMP SG), which is comprised of regional presidents from Kaiser Permanente's eight regions, members of Kaiser Permanente's National Leadership Team, the leaders of the Permanente medical groups, and union leaders in the Coalition of Kaiser Permanente Unions. The union leadership group typically includes at least one representative from each of the Coalition's affiliated unions. The LMP SG meets annually to "review the progress of the Partnership, the implementation of the National Agreement, and to approve the program and budget for the Partnership for the coming year," says Tanya Wallace, a field director for the Coalition of Kaiser Permanente Unions.<sup>7</sup> The Office of Labor Management Partnership (OLMP) is overseen by the labor and management co-chairs of the LMP and is "empowered to execute the plan and budget adopted each year by the LMP strategy group," adds Wallace.

In between the annual meetings of the LMP SG, the executive committee of the SG convenes once a month to oversee the activities and direction of the LMP. This group consists of executive leadership from both Kaiser Permanente and the Coalition. At the local union level, the union steering committee (USC) assembles three times a year to review the work of the Coalition and to educate members about its progress. Representatives from all of the local unions in the Coalition attend these meetings, alongside staff and rank-and-file union members.

The regional partnership structure for most of Kaiser Permanente's regions mimics the national structure in that each is comprised of a regional LMP council populated by labor and management leaders for that region. "In addition, each medical center will have a governing body for labor, management, and the combined group that forms the LMP strategy group or steering committee," says Wallace.

LMP infrastructure and activities are funded primarily by the *partnership trust*, which collects monies from the 9 cents per hour that is set aside by Coalition union members and funds provided by Kaiser Permanente. The trust is overseen by six trustees, who are also members of the LMP strategy group

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<sup>6</sup> Kochan (2009), p. 42.

<sup>7</sup> E-mail communication with Tanya Wallace on 1/5/11.

During its first few years, the LMP focused largely on improving labor relations and communication and developing a handful of collaborative projects in Kaiser Permanente hospitals and clinics to improve patient care. Although the partnership had a significant positive impact on labor relations and several joint labor-management projects were successful, the partnership process did not consistently improve patient care, quality of employee work life, and the engagement of front-line staff in partnership activities.

To improve the overall effectiveness of partnership activities in these areas, the 2005 National Agreement set forth “appropriate structures and processes for Partnership interaction to take place” that would involve front-line staff and management in ongoing collaboration at the department level.<sup>8</sup> These structures and processes would come to be embodied in the unit-based team (UBT). In the following sections, this report will detail the genesis, general structure, and goals of UBTs across Kaiser Permanente. In addition, it will chart the progress, outcomes, and challenges of UBT activities at two different Kaiser Permanente facilities: San Rafael Medical Center in Northern California and San Diego Medical Center in Southern California. These descriptions will highlight the involvement of unions in sustaining UBT work and will provide specific examples of how UBTs have affected clinical outcomes and front-line staff engagement at the two medical centers.

### **Structure and Goals of Unit-Based Teams across Kaiser Permanente**

Unit-Based Teams (UBTs) were established in the 2005 National Agreement between Kaiser Permanente and the Coalition of Kaiser Permanente Unions to provide a venue for staff, management, and union stewards to work collaboratively on performance and quality improvement projects. It was the vision of senior labor and management leaders to establish UBTs in all departments throughout Kaiser Permanente medical centers to achieve the quality of care and staff satisfaction improvements that had been not fully realized by earlier partnership work.

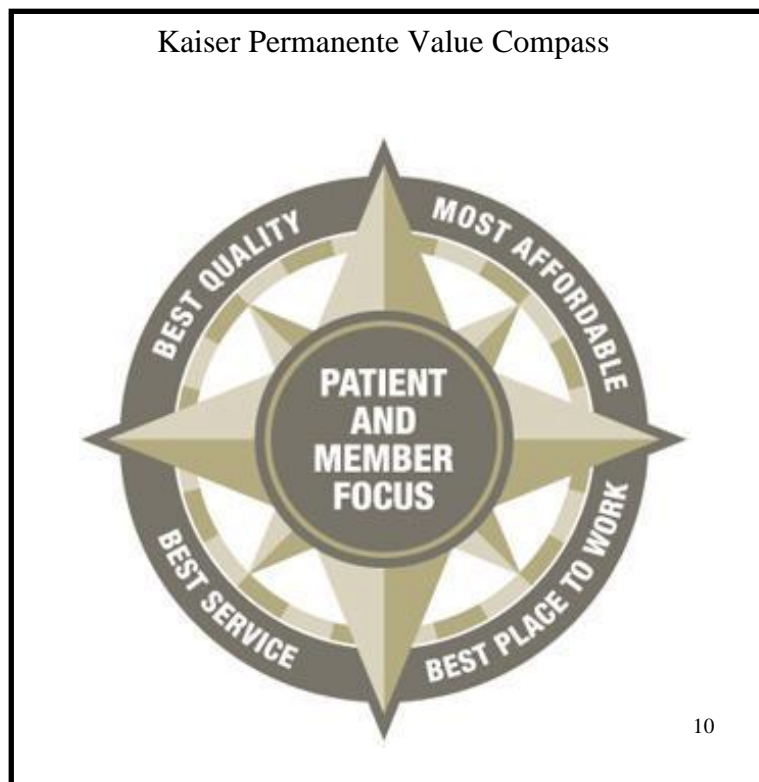
In 2005, Kaiser Permanente set forth a bold plan for introducing UBTs at all of its medical centers: The goal was to have UBTs in 15 percent of all units by December 2007, 40 percent by December 2008, 70 percent by December 2009, and 100 percent by December 2010.<sup>9</sup> The achievement of these goals has taken time, and UBTs are not yet a ubiquitous presence across Kaiser Permanente. As of January 2011, there are 3,417 teams in all eight Kaiser Permanente Regions, involving 102,775 employees.

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<sup>8</sup> See Appendix A for collective bargaining language from the 2005 and 2010 National Agreements regarding unit-based work.

<sup>9</sup> Kochan (2009), p. 192.

UBTs are comprised of all members in a “natural work unit,” which includes managers, shop stewards, front-line healthcare providers, and support staff. UBT members are charged with participating in unit planning, goal-setting, performance evaluation, budgeting and staffing decisions, and problem-solving. All work done in these areas is guided by the “Value Compass,” which places the patient at the center of initiatives to advance Kaiser Permanente and the Coalition’s strategic goals in the following categories: best place to work, most affordable, best quality, and best service. The value compass aligns unit-based improvement goals with Kaiser Permanente’s overarching aims and keeps the patient as the primary focus of all work.



As mentioned above, UBTs are designed to involve every member of a “natural work unit” or department. In large departments or multi-site departments, UBTs may use a representative model in which staff members from each shift or from each facility are chosen by their peers with guidance from union representatives to serve as part of a UBT representative group. The representative group reports back pertinent information to all staff members who, while not in the representative group, are still members of the UBT.

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<sup>10</sup> Kaiser Permanente Labor Management Partnership, <http://www.lmpartnership.org/ubt/rapid-improvement-model/value-compass>.

For example, at San Rafael Medical Center in Northern California, the Clinical Laboratory department consists of fifty employees at the medical center's main location and three satellite clinics. Accordingly, the UBT representative group includes members from each position and each shift, including clinical lab scientists, lab assistants, clerical employees, night shift, day shift, and satellite clinics. For an illustrative counterexample also from San Rafael, the Operator Services department is comprised of only 13 employees. The small number of staff members makes it possible for the department to operate without a representative group. Regardless of unit size, all staff members participate in UBT activities and have a responsibility to support partnership principles, complete trainings, express their ideas, communicate respectfully with each other and their co-leads, participate in decision making, and implement agreements.<sup>11</sup>

Each team is headed by co-leads chosen from both labor and management.<sup>12</sup> Labor co-leads are typically selected by representative group members and can be union shop stewards or other union activists. Management co-leads are recruited by a department's management and are typically department directors, assistant administrators, or administrators. Co-leads are responsible for advocating for partnership success, preparing for meetings and huddles, communicating early and often, keeping team records, troubleshooting, making off-line decisions when necessary, sharing information with the team, building relationships, and sharing expectations with co-leads.<sup>13</sup>

Each UBT also benefits from the support of dedicated labor and management *sponsors*, who provide a framework for accountability. Management sponsors, who are usually department heads, have specific responsibilities: supporting the partnership, keeping the UBT visible, supporting UBT success, authorizing and advocating for change, allocating resources for success, and generally “walking the talk”—in other words, enacting the principles of the partnership in their managerial duties.<sup>14</sup> They also have authority for allocating budgetary funds for UBT projects and initiatives.

Like management sponsors, union representative sponsors play a unique role in fostering the growth of UBTs. “Sponsorship is key. It is critical,” says José Simoes, Director of the Service Employees International Union-United Healthcare Workers West (SEIU-UHW) Kaiser Permanente Division, because union representatives serve as mentors for both newly formed and

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<sup>11</sup> Kaiser Permanente Labor Management Partnership, <http://www.lmpartnership.org/ubt/starting-and-running-a-ubt>.

<sup>12</sup> Some teams also involve a physician co-lead alongside those from labor and management. Alternatively, some medical centers and regions have a “point” physician who communicates the perspective and input of the physician group. Paul Staley, Vice President of Operational Initiatives and Performance Improvement at Kaiser Permanente, estimates that 25-30 percent of all UBTs have some form of physician involvement and engagement.

<sup>13</sup> Kaiser Permanente Labor Management Partnership, <http://www.lmpartnership.org/ubt/starting-and-running-a-ubt>.

<sup>14</sup> Ibid.



high-performing teams.<sup>15</sup> They help staff members understand the divisions between partnership work and collective bargaining and give successful teams suggestions for how to sustain engagement. Furthermore, the very presence of union sponsors demonstrates strong union support for UBT activities. Bill Robotka, a union representative and Clinical Laboratory Services UBT sponsor from Engineers and Scientists of California-International Federation of Professional and Technical Engineers (ESC-IFPTE) Local 20 sees himself as a “friendly uncle” who occasionally contributes ideas at UBT meetings but largely serves to equalize the balance of power with management.<sup>16</sup>

UBT co-leads and members receive several types of training to ensure that their team functions efficiently, productively, and respectfully. Co-leads are required to attend an 8-hour workshop that introduces them to the objectives of UBT work and their roles as co-leads. All UBT members are expected to enter into the team problem-solving process after the following trainings: *Labor Management Partnership orientation*, *Interest-Based Problem Solving/Consensus Decision-Making*, a general overview of the *Rapid Improvement Model* (RIM+), and *Business Literacy*.<sup>17</sup> It is also recommended that at least one UBT member take *Systems of Safety* training. Those joining the UBT from a management background are exposed to *Managing in a Partnering Environment* as well as *Performance Improvement Leadership* training, while those from a labor background receive *Effective Stakeholder* training alongside *Performance Improvement Leadership* training. These training modules were born out of the Kaiser Permanente and Coalition of Kaiser Permanente Unions’ National Agreements and help ensure that all members of the UBT are adequately prepared to undertake projects collaboratively and effectively.

While training for UBT members is a product of Kaiser Permanente’s LMP, the teams are largely responsible for setting their own goals based on the strategic goals of their region and tracking the results of their improvement projects.<sup>18</sup> “Early in a team’s development, UBTs identify performance indicators that reflect business and job satisfaction, are meaningful to their unit, and support national, regional, and local goals.”<sup>19</sup> UBT co-leads record their projects and performance progress by entering data into the UBT Tracker, an online tool introduced in 2009 that monitors projects and data by unit, facility, and region. The UBT Tracker also records each

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<sup>15</sup> Interview with José Simoes on 6/28/11.

<sup>16</sup> Interview with Bill Robotka on 2/23/11.

<sup>17</sup> The Rapid Improvement Model is comprised of four steps: setting goals, establishing measures, selecting changes, and testing changes using the Plan, Do, Study, Act cycle. For more information see Appendix A.

<sup>18</sup> Often individual medical centers will have their own unique methods for tracking their projects and outcomes. San Diego Medical Center, which will be discussed later in this report, is one such site.

<sup>19</sup> Kaiser Permanente Labor Management Partnership, <http://www.lmpartnership.org/ubt/track-performance>.

UBT's performance evaluation, which is measured on a scale from 1 to 5 and is based on Path to Performance Criteria.<sup>20</sup> The 5-point scale is comprised of the following gradations:

1. Pre-Team Climate
2. Foundational
3. Transitional
4. Operational
5. High-Performing

The Path to Performance evaluates UBTs in the following areas: sponsorship, leadership, training, team process, team member engagement, use of tools, and goals and performance.

Since their launch in 2005, UBTs have rapidly become a powerful platform for both front-line staff and management to participate in quality and performance improvement and dynamic problem-solving. Currently, Kaiser Permanente and the union coalition has a robust plan for increasing the number of teams that are high-performing. According to the 2010 National Agreement, by 2011 Kaiser Permanente aims to double the number of high-performing UBTs that existed at the end of 2010, add another 20 percent in 2012, and add 20 percent more in 2013. As of November 1, 2011, the LMP has already surpassed the goal of doubling the number of high-performing teams.

As of November 1, 2011, 880 teams (26 percent) of UBTs are at level 1 (Pre-Team Climate) and 142 teams (4 percent) are at level 5 (High Performing), according to Path to Performance metrics. Now Kaiser Permanente and the Coalition of Kaiser Permanente Unions not only face the challenge of increasing the number of high-performing teams as per the above-mentioned plan but also, as teams move up through the Path to Performance rankings, developing a strategy for supporting and deepening the activities of teams that have already reached a high level of performance.<sup>21</sup>

## **Labor-Management Partnership Activities at San Rafael Medical Center**

### *Overview*

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<sup>20</sup> See Appendix A for the Path to Performance evaluation criteria.

<sup>21</sup> In fiscal year 2011, the LMP has seen considerable upward movement of teams through the Path to Performance evaluation system. Compare the percentages of teams at level 1 and level 5 from the fourth quarter of 2011 cited above to the percentages from the first quarter noted here. The first quarter of 2011 saw 1,603 teams (46 percent) at Level 1 and 76 teams (2 percent) at Level 5.

San Rafael Medical Center was established in 1976 and is one of the two medical centers in the Marin Sonoma Service Area of the Northern California Division of Kaiser Permanente. It currently serves over 100,000 Kaiser Permanente members at its main hospital and two outpatient clinics in Novato and Petaluma. With 226 beds, the medical center employs roughly 300 physicians and 1,000 staff for both its hospital and home health services. There are three unions present at San Rafael: United Healthcare Workers (SEIU-UHW), representing healthcare workers in hospitals, nursing homes, and in the community as home care providers; Engineers and Scientists of California Local 20 (ESC), representing engineering, technical, and scientific employees throughout Northern California; and the California Nurses Association (CNA). The CNA is not part of the labor-management partnership at San Rafael.

San Rafael has a strong history of collaborative culture and alignment of goals for both labor and management. When Kaiser Permanente's LMP was instituted in 1997, "partnership with a small p had already existed at San Rafael," notes Patricia Kendall (Medical Group Administrator).<sup>22</sup> Therefore, when UBTs were introduced at San Rafael during the Northern California regional kickoff in 2007, the spirit of teamwork essential to sustaining UBTs was already familiar to the medical center's employees. Expressing an opinion common to many San Rafael managers, Eileen Kilgariff (RN and Manager, OB-GYN) notes that the UBTs did not introduce much of a culture change for her because her management style was already steeped in collaborative activities with staff.<sup>23</sup>

Although San Rafael had many of the cultural elements in place to launch UBT activities, the teams themselves needed to be created, as previous collaborative work took place informally. In 2007 the medical center piloted five teams (referred to as Targeted UBTs or T-UBTs) in Surgical Subspecialties, Admitting, Patient Mobility, Environmental Services, and Clinical Laboratory Science. These five teams focused their activity on one of the following issues: attendance, overtime, missed meals and breaks, outpatient service, and inpatient service.

From the five T-UBT pilots, San Rafael learned that consistency was a critical factor in launching the teams. Therefore, when 55 additional UBTs were introduced at the medical center in 2009, Joan Mah (Senior Unit-Based Team Consultant, San Rafael) states that the process began with an "initial meeting with the co-leads to share with them the expectations regarding team composition, their roles and responsibilities...and how they would gather their data and report their results."<sup>24</sup> As of November 1, 2011, there are 56 teams operating at San Rafael.

### *UBT Structure and Process*

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<sup>22</sup> Interview with Patricia Kendall on 3/16/11.

<sup>23</sup> Interview with Eileen Kilgariff on 2/10/11.

<sup>24</sup> Interview with Joan Mah on 6/6/11.

The majority of the UBTs at San Rafael involve entire departments. However, there are some larger departments across San Rafael's three inpatient and outpatient facilities that use the representative model. For these teams, participants are chosen on a voluntary or elected basis. According to Joan Mah, representative group members are charged with fostering "two-way communication" between all members of the department. Team member roles and responsibilities conform to the general model described in the previous section.

Teams at San Rafael are expected to meet at least one hour per month. Additional time may be spent working on specific initiatives, and many teams convene daily huddles that last ten to twenty minutes. As previously stated, the nurses at San Rafael are not officially involved in UBT and other labor-management partnership work. Nevertheless, Mah notes that nurses "are welcome to join our teams as subject matter experts." Similarly, physicians have had a limited role in UBT activities at San Rafael. According to Patricia Kendall, the medical center has taken a "natural approach" to physician involvement and continues to leave the door open to physician participation.<sup>25</sup>

Each UBT has a unique set of goals and chooses its own projects. UBTs are asked to focus on three general categories: workplace safety, attendance, and service. The metrics used to assess these projects are regional and are tracked at different intervals throughout the year. A variety of methods and venues are used to share information regarding the projects and successes of the medical center's UBTs. Manager-steward meetings provide a forum for discussing the progress of UBT activities. In addition, Mah is in dialogue with San Rafael's LMP steering committee (comprised of the medical group administrator, the chief operation officer/chief nursing officer, managers, and labor representatives). She continually keeps the committee informed about "where we are with our teams in terms of levels. I also share with them what trainings I am implementing and what the regional LMP is requiring of me to move our UBTs forward."<sup>26</sup>

UBT consultants provide critical training, information about the activities of other teams, and a connection between UBTs and regional LMP leaders. Joan Mah has been at San Rafael since 2000 and has recently taken on the role of Senior UBT Consultant. She attends regional meetings to discuss the progress of the medical center's teams and to gather insight as to how they might further improve. Many co-leaders, team members, and administrators at San Rafael stress not only the value of a strong, central leader but also specifically Mah's own personal commitment to UBT activities. She has been a driver for change and demands nothing short of excellence from the teams she supports.

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<sup>25</sup> Interview with Patricia Kendall on 3/16/11.

<sup>26</sup> Interview with Joan Mah on 6/6/11.

To illustrate the scope and impact of UBT work at San Rafael, the following sections will describe the activities and outcomes of three UBTs at San Rafael Medical Center: Clinical Laboratory Services, Obstetrics and Gynecology, and Operator Services.

#### *Clinical Laboratory Services (CLS): Projects and Outcomes*

The Clinical Laboratory Services (CLS) department, which consists of 70 employees and three managers, formed its representative model UBT in 2007. Members of the UBT's representative group are drawn from staff at San Rafael's main hospital and outpatient facilities. In past years, the representative group has included staff from day, night, and evening shifts. However, because interest in participating in UBT activities fluctuates, as of the winter of 2011 there are only representatives from the day shift.

The CLS department had mixed experiences with labor-management partnerships before its UBT was established. The creation of a UBT gave structure to the department's partnership activities and has allowed CLS staff and management to make significant changes to specific work processes and the overall work environment in laboratories at San Rafael. Because of the nature of their work, CLS staff members decided to focus their UBT efforts on issues of workplace safety, with an additional emphasis on attendance, missed meals and breaks, and overtime.

The CLS UBT is remarkably open to collaborating and exchanging ideas with other departments at Kaiser Permanente facilities. Ramona Guiles, a former UBT co-leader, recounts traveling to another facility to assess the ergonomic value of the chairs being used successfully in its drawing station and

#### Workplace-Related Injuries and the Bottom Line

The healthcare industry is one of the largest and most dangerous employment sectors in the United States. According to data released by the Bureau of Labor Statistics, nursing aides, orderlies, and attendants alone experienced 283 cases of workplace injury (requiring time off) per 10,000 full-time workers in 2010. This is more than double the total of 118 cases per 10,000 for all public and private employees.

Unsafe work environments negatively affect the bottom line of healthcare organizations, which are forced not only to compensate the injured employee but also to assume the costs of hiring temporary replacement staff, dealing with lowered morale and efficiency, and replacing any damaged equipment. It has been estimated that these indirect costs amount to 3 or 4 times the direct costs associated with compensating injured workers.

Workplace injuries can be avoided by growing a culture of safety among front-line staff in which they feel comfortable discussing safe work practices with their peers and engage in active problem-solving, from securing appropriate equipment to developing safety protocols.

securing these chairs for San Rafael.<sup>27</sup> The department has also created a workplace safety team to identify and address the safety concerns of all staff. This team has opened up its meetings to other departments struggling with workplace safety issues. The CLS department had zero reported workplace-related injuries in 2010 and two in the first five months of 2011.<sup>28</sup>

The most significant CLS UBT initiative to date was the remodeling of the laboratories at San Rafael and at the clinic in Novato. This project began in October 2008 and was completed in 2009. The UBT was intimately involved with all aspects of the remodeling process, modifying and approving blueprints and subsequently monitoring the success of the remodel. The UBT was also vigilant in addressing workplace safety issues that arose during the redesign process such as replacing the old laboratory flooring which caused a high number of workplace injuries with safer alternative flooring.

The CLS UBT also engaged meaningfully with the medical center's initiative to become a stroke center of excellence in 2009. At the time, the CLS department fell short in terms of meeting the suggested 45-minute Turnaround Time (TAT) for performing stroke alert patients' tests. The team then determined to analyze and solve the problem. Using "mock stroke alerts," the department received drawn blood samples from the lab assistant in the Emergency Department, performed the necessary tests, and reported the results. In this way, the UBT arrived at a detailed understanding of the post-stroke testing process and came up with a list of suggestions for improving their TAT as follows: The CLS department supervisor would need to confirm the lab assistant's acceptance of the assignment to draw blood samples from the stroke alert patient, and the CLS Chemistry staff would be provided with a timer to remove samples from the centrifuge in a prompt manner. The department was also encouraged to record all stroke alert cases in a notebook, allowing for easy troubleshooting. The UBT currently tracks the department's TAT, and staff are generally able to achieve the 45-minute benchmark.

Finally, as described above, the CLS UBT has been actively involved in improving workplace safety and staff communication since its inception in 2007. Because the CLS department is open 24 hours a day, 7 days a week, and is housed at four different facilities, the UBT found that information regarding department meetings was reaching only 55 percent of staff members. Even scheduling additional meetings each month failed to increase the amount of staff participation. In 2008 the UBT learned that other departments within San Rafael were successfully using huddles to improve staff communication and dissemination of information and decided to follow suit. Currently the CLS department holds brief huddles between the day and evening shifts to discuss safety issues. These huddles are initiated by shift supervisors, shop stewards, or department managers. The CLS UBT originally aimed to hold 20 huddles per month, and in July 2011 the department surpassed that goal, conducting 28 huddles that month.

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<sup>27</sup> Interview with Ramona Guiles on 2/28/11.

<sup>28</sup> Comparative data from previous months was not available.

From streamlining clinical procedures to promoting workplace safety, the CLS UBT has harnessed the insight of its staff members to transform a department into a safe and efficient workplace designed by its staff, for its staff.

### *Obstetrics and Gynecology (OB-GYN): Projects and Outcomes*

The OB-GYN department consists of 26 staff members, and its UBT uses the representative group model. The team was established in 2009 and currently meets once a month. According to Eileen Kilgariff (RN, Nurse Manager), the UBT is actively involved in all departmental changes.<sup>29</sup>

In 2011 the OB-GYN UBT decided to undertake a series of projects to improve staff interaction with patients, along with patients' access to care services. With these goals in mind, the team worked to decrease the department's reliance on costly, hard-to-read print materials and encourage OB-GYN patients to sign up for Kaiser Permanente's user-friendly online information services. In addition, the team revised the department's homepage to make it more easily navigable by patients. As a result, the team decreased the number of print materials distributed to patients by 60 percent. This decrease allowed the department to cut costs, improve its web presence, communicate more effectively with patients, and reduce environmental impact by limiting its dependence on paper.

The UBT also focused on improving attendance and employee wellness by promoting exercise and healthy diet via the "Biggest Department" challenge, a lunch-hour initiative that introduced staff to healthy diets and stress reduction techniques. However, attendance remains a difficult sticking point for the team, as its various efforts have not led to significant improvements. "We tried contests between facilities, drawings for prizes, and shame and

### "Going Green" in Healthcare

In the recent push to restructure the United States healthcare system to increase accessibility, quality, and affordability, ecological sustainability has not taken center stage in most discussions. Many hospital leaders are wary of taking steps to mitigate the environmental impact of their institutions when they are already under strong internal and external financial pressure.

However, there are numerous opportunities for hospitals to "go green" while simultaneously saving money. For example, according to a 2010 study published in *Academic Medicine*, reprocessing single-use equipment can reduce medical device costs by 50% and divert thousands of tons of waste from landfills. As San Rafael's OB-GYN unit focused on reducing paper goods, the University of Maryland Medical Center made an effort to re-sterilize sharps containers to save the medical center \$77,000 in supplies and disposal costs. Going green is not only the right thing to do for the environment but also for the bottom line of healthcare organizations.

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<sup>29</sup> Interview with Eileen Kilgariff on 2/10/11.

recognition without any measurable changes,” notes Eileen Kilgariff.<sup>30</sup> In 2012, the team hopes to cut down one missed day per facility, using a variety of innovative techniques.

The OB-GYN UBT is still struggling to communicate effectively with unit staff members. Some staff members resent the amount of energy required to carry out UBT initiatives—a situation that could be improved via effective information and communication. Nevertheless, the team has been able to raise considerable awareness about the importance of healthy lifestyles and patient courtesy among staff, and change continues to permeate the unit slowly but surely.

#### *Operator Services: Projects and Outcomes*

The Operator Services UBT includes all 13 department staff members and two managers and meets once a month. At first, the UBT concentrated on improving collaborative decision-making but soon progressed to more specific unit problems. The team currently focuses on issues of budgeting, safety, and attendance.

Beginning in 2009, the UBT began a series of projects to help improve patient satisfaction and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.<sup>31</sup> The team decided that the most effective way to improve these scores would be to decrease the number of overhead pages (announcements) in the hospital. This measure, they reasoned, would make the hospital quieter, leading to higher patient satisfaction. It would also create staff efficiencies by allowing operators to answer more calls instead of making frequent announcements.

“In 2009 we went from 450 overhead pages per month down to 422 pages for the entire year. That is very significant.”

Bev Cleland, Manager and UBT Sponsor, Operator Services

Earlier, Operator Services department staff relied on overhead paging to get in touch with staff members because it was simply the easiest mode of communication. “We also used to announce meetings and special events overhead. This created a lot of overhead noise for inpatients and in our integrated facility in general,” notes Bev Cleland (Manager and UBT Sponsor, Operator Services).<sup>32</sup> The UBT proposed to eliminate all overhead pages except for medical codes, a solution that was approved and implemented throughout the medical center. “In 2009 we went

<sup>30</sup> Interview with Eileen Kilgariff on 2/10/11.

<sup>31</sup> HCAHPS scores provide information about hospital quality of care from a consumer perspective. They are intended to offer a standardized survey instrument and data collection methodology to measure patients’ perspectives on their care in the following eight areas: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, and quietness of the hospital environment.

<sup>32</sup> Unfortunately the hospital’s HCAHPS score remained the same due to a renovation project which contributed to the noise level at the hospital. Interview with Bev Cleland on 3/15/11.



from 450 overhead pages per month down to 422 pages for the entire year. That is very significant,” says Cleland.<sup>33</sup>

In 2010, the UBT undertook a second project, one that harnessed the skills and knowledge of operators to improve Kaiser Permanente members’ access to all departments at San Rafael. The team designed a simple, four-question protocol that would expedite member calls and connect them directly to the manager of the relevant department, when appropriate. Team members surveyed department staff members about the kinds of calls they received most and the issues they considered most essential for establishing the protocol. “Because they live it, they know what is needed on the sheet,” says Amy Mahoney (Management Co-Lead, Operator Services).<sup>34</sup> Ultimately, the UBT devised a protocol that consisted of asking callers for the following information:

- their name and medical record number;
- whether they had a telephone appointment;
- whether they received a call back; and
- whether they were having problems accessing the necessary department.

When called for, the operator would apologize and inform callers that they would be transferred live to the manager of the department in question. Bev Cleland, Operator Services supervisor and UBT sponsor, presented these ideas to San Rafael’s Clinical Administration and subsequently at the medical center’s managers meeting. Managers were eager to learn how they could improve work processes in their own department from the perspective of a Kaiser Permanente member and approved the implementation of the project.

Finally, the UBT took on the challenge of helping the department save money while maintaining quality of service. The team quickly identified a clear way to realize savings: they could survive on certain low call volume days without paying staff members overtime to cover for other staff members on vacation or sick leave (backfilling). By reducing staffing levels in this way, the department was able to save \$51,000 in 2010. Quality of service did not suffer, and San Rafael ended the year with the least amount of abandoned (dropped) calls in the Northern California region.

The projects developed by the Operator Services UBT are a powerful illustration of the ability of UBT work to improve patient satisfaction, cost savings, workflow efficiency, staff engagement, and inter-departmental collaboration.

### *Medical Center-Wide Outcomes*

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<sup>33</sup> Ibid.

<sup>34</sup> Interview with Amy Mahoney on 3/8/11.

As Tony Fiorello notes (CNO and COO, San Rafael), UBTs have provided for a way for the goals of the partnership to be realized at the local level and a common framework for problem-solving.<sup>35</sup> Furthermore, the problem-solving process itself has been improved with the additional input of front-line staff. “It makes a huge difference when you have front-line staff involved,” says Ramona Guiles (former CLS UBT labor co-lead), because they have intimate knowledge of work processes and creative solutions for streamlining those processes.<sup>36</sup> Even further, Guiles notes, front-line staff have become increasingly vocal about their needs in light of problems that arise on their units. She remarks that nobody is afraid to say, “We need to change this,” as the UBT now provides a space in which concerns can be heard and addressed.

In addition, UBT work has also fostered increased transparency at San Rafael. Staff now has access to departmental budgets, including information about managers’ salaries. When staff proposes a project, the team reviews the department’s budget with managers to test the project’s financial viability. As well, staff has access to the same training classes as managers do, which includes business literacy courses. This has “leveled the playing field,” comments Denise Senior (UHW Representative Chair).<sup>37</sup>

Finally, UBT work has encouraged greater openness and willingness to change on the part of both staff and management. There is a collegiality between labor and management that extends to physicians, notes Patricia Kendall (Medical Group Administrator, San Rafael).<sup>38</sup>

### *Impact of and on the Union*

Through their involvement in UBT work, UHW and ESC Local 20 have become more engaged in discussions around remodeling and have taken an active interest in technology issues. Accordingly, the unions are now offering computer classes to help their members stay current with developments in their fields, keep their licenses, and advance within Kaiser Permanente.

According to Bill Robotka, UBTs have allowed the unions to become much more engaged at Kaiser Permanente than at any other healthcare organization, shifting the focus of labor relations away from adversarial conflict resolution to building relationships between staff and management.<sup>39</sup> José Simoes notes that UBT work has also encouraged UHW members in particular to think about union-building activities in a new way and to build the capacity of the union to engage with partnership activities.<sup>40</sup> UHW, alongside the other unions in the Coalition

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<sup>35</sup> Interview with Tony Fiorello on 3/28/11.

<sup>36</sup> Interview with Ramona Guiles on 2/28/11.

<sup>37</sup> Interview with Denise Senior on 3/28/11.

<sup>38</sup> Interview with Patricia Kendall on 3/16/11.

<sup>39</sup> Interview with Bill Robotka on 2/23/11.

<sup>40</sup> Interview with José Simoes on 6/28/11.

of Kaiser Permanente Unions, was initially involved in UBT work at the most basic level: negotiating the formation of UBTs as part of the National Agreement and ensuring that a labor-management partnership approach would undergird the operational framework of Kaiser Permanente. Now that UBTs have been created across the organization and continue to thrive, UHW is exploring the best ways to prepare its members to work effectively within the partnership environment. Simoes argues that participation in partnership activities benefits the union and its members by giving front-line staff a real voice in the workplace. This, he believes, makes an even larger impact than the actual contract that the union negotiates with Kaiser Permanente.

Finally, UBT activities have led to a change in the role of the union shop steward and union representative. Because UBT labor co-leads are often stewards, the steward role has been expanded from one that mainly handles grievances to one that mentors staff members in their respective departments. Union representatives as well must assume a mentoring and coaching rather than adversarial role and provide support to teams, whether they are already functioning at a high level or struggling to get off the ground. Union leadership is charged with providing training and support for stewards and representatives filling these new roles.

#### *Current Challenges*

Despite the UBTs' many successes in influencing positive outcomes in their departments and at the medical center as a whole, there are still significant challenges to UBT activities at San Rafael. Major areas include the following:

1. **Lack of nurse involvement:** As noted above, CNA nurses are not officially involved in unit-based teamwork—an ongoing barrier to the success of UBT activities at San Rafael. This non-involvement policy is rooted in the ideological approach to labor relations adopted by the CNA. Because nurses are significant players at the unit level, their lack of participation in UBTs can create tension between nurses, other healthcare professionals, and management. As Tony Fiorello notes, the notable absence of nurses reduces the effectiveness of problem-solving activities, communication, and departmental efficiency.<sup>41</sup> Further, their absence diminishes the UBTs' potential scope of impact on restructuring clinical processes and the workplace environment.
2. **Staff engagement and communication:** It remains challenging to generate sufficient support and enthusiasm from staff on each unit for UBT work. The solution lies in improved communication, which has not always been frequent or clear, between UBT representative groups and unit staff. When communication breaks down, it is difficult for staff to understand the purpose of projects, the broader goals of the UBTs, and the larger

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<sup>41</sup> Interview with Tony Fiorello on 3/28/11.

value of partnership work. When staff sees the impact UBTs can have at the unit level, they tend to become more supportive of UBT activities.

3. **Supportive management/union sponsors and the limited reach of partnership:** Just as it can be difficult to elicit total staff support for UBT activities in any given department, it can be doubly challenging when a manager is perceived to be unsupportive of UBT work. Some staff members note that in some cases, managers have continued to make decisions outside the partnership structure without consulting staff. Similarly, there is a perception among some managers that the union will protect a low-performing employee to the detriment of quality improvement initiatives at the hospital level. As well, union representatives do not consistently sponsor UBTs, and union leadership can be just as resistant to change as management.
4. **Scheduling challenges:** Because there are multiple competing demands on staff and management's time at San Rafael, meetings can consume a significant portion of an employee's day. Some departments have addressed this challenge by replacing department meetings with a daily huddle that lasts only ten or twenty minutes. However, developing methods and carving out time to work on UBT projects and communicate the process to all stakeholders can still prove difficult.

### **Labor-Management Partnership Activities in the San Diego Medical Center Area**

#### *Overview*

The San Diego Medical Center area is the third largest service area in Kaiser Permanente, with 508,000 patient-members living in the surrounding community. The area can be characterized as diverse in terms of both ethnicity and income levels. It includes one medical center, 22 outpatient clinics, and a home health care division that employs more than 7,400 staff and 1,100 physicians.

The unions representing employees in the San Diego service area include the following:

- Office and Professional Employees International Union (OPEIU)
- Local 30, which represents technical and professional staff, service and maintenance workers, and clerical employees
- United Nurses Associations of California-American Federation of State County and Municipal Employees (UNAC-AFSCME), which represents RNs, nurse practitioners, and other nursing job classifications
- United Food and Commercial Workers (UFCW) Local 135, representing pharmacy technicians and clinical scientists
- The Kaiser Permanente Nurse Anesthetist Association (KPNAA), representing certified registered nurse anesthetists

Psychologists and social workers are represented by the National Union of Healthcare Workers (NUHW), which is not part of the labor-management partnership. Unlike at San Rafael Medical

Center where nurses are represented by the CNA, the nurses represented by UNAC at San Diego are formally part of the labor-management partnership.

The original vehicle for the partnership in the San Diego service area consisted of a steering committee that included leadership from all partnering unions as well as the Kaiser Medical Group and the Kaiser Hospitals and Health Plan. During the start-up period, many of the partnership's activities were focused on getting "the LMP steering committee established and functional," said Kaiser Permanente LMP consultant Sylvia Wallace.<sup>42</sup> There were a few project-based teams engaged in workplace safety activities, but the partnership did not yet reach many front-line workers and was mostly limited to higher-ranking labor and management leadership in the area.

After unit-based teams were established by the 2005 National Agreement between Kaiser Permanente and the Coalition of Kaiser Permanente Unions, Wallace states that the San Diego Area steering committee spent time assessing "what needed to be done to help the UBTs get started, trained, and focused on improvement of performance" in the following areas: attendance, clinical quality, inpatient and outpatient service, workplace safety, and workforce health. At that point, adds Wallace, "there were day-long mandatory LMP training classes for employees, covering basics such as LMP orientation, consensus decision-making, working in a partnership environment," and other subjects.<sup>43</sup> When first established, these classes used regional program curricula. They were later streamlined and customized to fit the needs of employees in the San Diego area and were eventually adjusted to be delivered at UBT meetings.

In the spring of 2007 the San Diego service area rolled out its first nine pilot *targeted unit-based teams* (T-UBTs), including the 4 North/South Postpartum and Intensive Care Unit/Critical Care unit at the San Diego Medical Center, clinical laboratory units in multiple locations, and the operating room at Otay Mesa. As of November 1, 2011, there are 133 teams in place. With the exception of approximately eight departments, all units and facilities in the San Diego area have a UBT. Of the 133 teams, five are functioning at Level 1 according to the Path to Performance evaluation rubric, eleven at Level 2, 35 at Level 3, and 82 at Level 4.<sup>44</sup> In fact, San Diego has been featured as one of the "brightest stars in the UBT constellation" by the Kaiser LMP.<sup>45</sup> Key factors contributing to the success of the partnership in the area have been the highly effective resource team, made up of UBT and LMP consultants, as well as the active involvement and

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<sup>42</sup> E-mail communication and interview with Sylvia Wallace on 8/9/11 and 8/12/11.

<sup>43</sup> E-mail communication and interview with Sylvia Wallace on 8/9/11 and 8/12/11.

<sup>44</sup> See Appendix A for Path to Performance evaluation information.

<sup>45</sup> "The San Diego UBT fair: Sharing successful practices," Kaiser Permanente Labor Management Partnership, <http://www.lmpartnership.org/>.

support of the service area's UBT labor and management sponsors (OPEIU Local 30's president and San Diego Medical Center's assistant administrator).

### *UBT Structure and Process*

Departments in the San Diego service area range in size from 7 to more than 300 employees. Although no specific number is used as a threshold, generally UBTs with membership of 25 and higher use the representative group model. Most UBTs have a representative group and typically include 8 to 10 individuals with broad representation from all job classifications and shifts. It is generally recommended that members of the UBT representative group serve for a maximum of 1 to 2 years to encourage the involvement of other staff members in this role. The representative group is responsible for continuing to evaluate their team's performance scorecard, communicate with the entire unit or department (frequently through a communication tree), and achieve LMP and department/service area goals.

UBTs are encouraged to meet at least 2 hours per month, with ad hoc meetings scheduled by co-leads. In addition to labor and management co-leads who directly oversee the work of the UBT, each team has a labor and a management sponsor who help remove roadblocks and obtain resources to support the teams' work. The UBT's management sponsor is typically the higher-ranking manager above the UBT management co-lead. Labor sponsors are union leaders or representatives for the employees in the relevant unit or department. UBT co-leads are expected to communicate with sponsors at least monthly and to discuss needs as they arise.

The UBT implementation team coordinates and supports the work of all UBTs in the San Diego service area. The implementation team has a labor co-lead (the president of OPEIU Local 30), a management co-lead (the assistant administrator of San Diego Medical Center), a lead UBT consultant, and about four LMP or UBT consultants. According to lead consultant Jenny Button, consultants at San Diego attend all UBT meetings to provide ongoing coaching and mentoring. These consultants also facilitate the training required for representative group members. In addition to the training mentioned above, partnership training includes sponsor training, RIM+ (Rapid Improvement Model) for co-leads, Performance Academy advanced training for co-leads, and other specialized classes such as business literacy, focused learning, and use of the UBT Tracker. Such training is necessary for the UBTs to advance toward becoming self-sustaining performance improvement teams.

As in other service areas, UBTs in San Diego are the vehicle for achieving performance improvements and have facility-wide and department-specific goals. While department-specific goals necessarily vary by unit, global goals include improving the following: attendance, clinical quality, healthy workforce, service quality (outpatient and inpatient care), workplace safety, access to care, patient safety, affordability, and employee engagement. To monitor progress in achieving these goals, the San Diego implementation team has employed evaluation mechanisms and metrics that are used throughout the Kaiser LMP as well as tools that were developed locally in the San Diego area. The unique measurement tools and performance improvement indicators

in the San Diego service area include the following: 1) The UBT Statit Scorecard: a web-based system that provides teams with regular access to their metrics “all in one place.” It includes a set of standard metrics such as attendance, quality (clinical goals), service (outpatient care experience), workplace safety, and affordability. UBTs can also customize the system to track variables specific to their own work. 2) The San Diego UBT Status Report: a local Excel-based worksheet that provides more detail than the UBT Tracker. It contains notes and recommendations specific to each team as well as team meeting times and team ratings, among other variables.

Other important factors influencing the effectiveness of UBT work across the service area are the implementation of communication systems within and between teams as well as mechanisms to diffuse best practices. Systems for communication within teams primarily include communication trees, bulletin boards, email, and daily huddles of 5 to 10 minutes, as well as the monthly meeting of the representative group. As can be seen in the chart below, communication trees mirror the structure of the UBTs such that each representative group member is responsible for communicating with a sub-group within the UBT.<sup>46</sup> This tool promotes one-on-one communication among all UBT members, thereby ensuring that UBT goals and processes are spread effectively throughout the unit or department.

Systems for communication between teams involve the use of newsletters and quarterly meetings of co-leads from all teams, which are held to exchange information and provide feedback on each other’s work. Communication systems between teams also serve as means to share best practices. UBT fairs are yet another way in which best practices are shared amongst teams in the San Diego area. At these fairs, UBTs display storyboards about their teams’ goals and recent outcomes.<sup>47</sup>

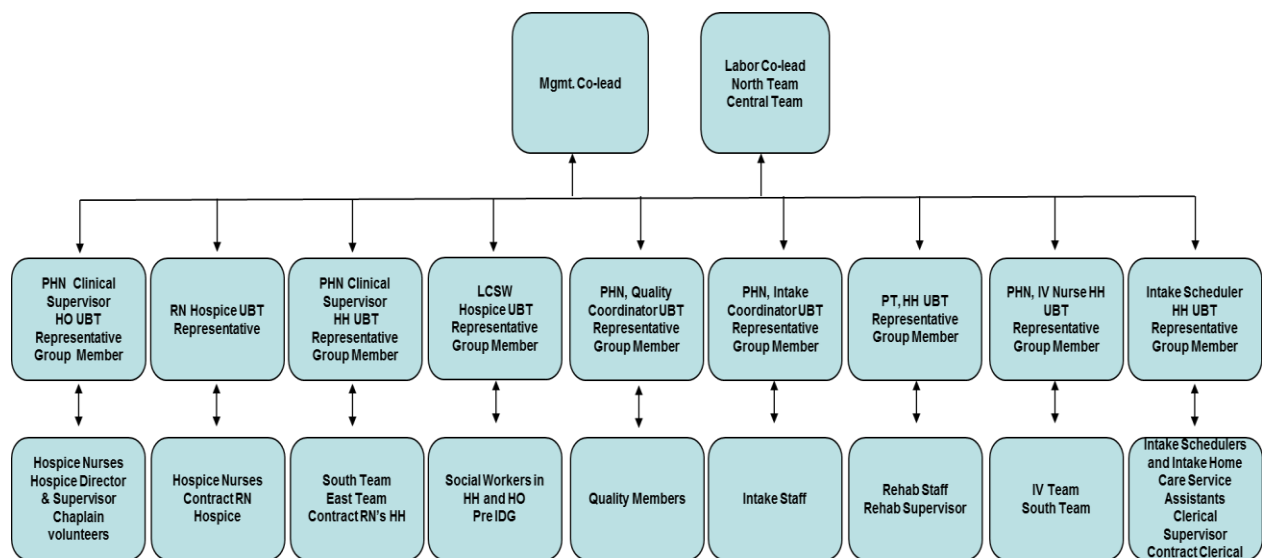
In summary, the key elements of the successful implementation of UBT and partnership work in the San Diego service area have included the strong commitment of the area’s union and management leadership, highly effective consultants, workforce engagement through the teams’ structure and participatory processes, and the use of advanced communication tools.

### *Communication Tree: Home Health Care UBT*

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<sup>46</sup> See Appendix A.

<sup>47</sup> Other areas that have hosted UBT fairs include Hawaii and Orange County. “The San Diego UBT Fair: Sharing successful practices,” Kaiser Permanente Labor Management Partnership, <http://www.lmpartnership.org/>.



The following sub-sections summarize results from the work of UBTs in three departments: Home Health Care, 2 North/2 South Medical Surgical Unit, and the Emergency Department.

#### *Home Health Care: Projects and Outcomes*

The Home Health Care UBT was formed in August 2009 in the Clinical Home Health Care Department, which comprises home health, hospice, and palliative care. The UBT has 11 members, who represent 138 home health, hospice, and palliative care staff.

In late 2009, the UBT began working on a project to improve the department's response time so that more patients could receive home care in a timelier manner. The team identified a problem of backlog related to long and unmanageable discharge lists, resulting in only 44 percent of patients being seen within the requisite 24-hour window following discharge from the hospital or referral from a physician. To tackle this problem, the team undertook Rapid Improvement Model (RIM+) training, created specific goals to increase the percentage of patients seen within 24 hours, and developed process flow maps.

Subsequently, the team was able to implement two changes to the unit's work process to improve response time. The first change involved streamlining the processing of the referral list, a practice previously implemented at Kaiser Permanente's Riverside Medical Center. This list is the queue of patients who are referred by a physician to home health care and typically includes 50 or more names on any given day. Under the old system, intake nurses would examine the daily list and ask a department clerk to process a referral. This cumbersome process involved several information exchanges between nurse and clerk to verify accuracy of the information, resulting in work duplication and delays. Using the new process, clerk involvement and middle steps were eliminated so that nurses could process the referral themselves.



The second change entailed restructuring the expected discharge list—a running daily record of patients expected to be discharged from the hospital and referred to home care. Under the old system, hospital discharge coordinators would add to this list those patients who were not expected to be discharged for several days or even weeks. The UBT changed the process so that discharge coordinators would only list patients designated to be discharged within 48 hours. Additionally, home care intake nurses began communicating with discharge coordinators throughout the day to receive updates on which patients were slated to be released that day. Finally, the team instituted a daily huddle to review and discuss patients’ care needs.

This project resulted in an increase in the number of referred home care patients who are seen within 24 hours from 44 percent of the total in January 2010 to 83 percent in November 2010. This percentage surpasses the 2010 regional target of 80 percent. Furthermore, the backlogged referral list that used to include more than 50 patient names now averages only 5 names, as of the winter of 2011.

The UBT plans to work more closely with the hospital to ease the transition from hospital to home care and to begin synchronizing efforts with the skilled nursing facilities that also refer patients to home care. In addition, the team is currently working to standardize the department’s use of Health Connect, Kaiser Permanente’s electronic medical record system, which went live for Home Health Care in May 2011. Initial assessments found that different team members were following different practices and experiencing a range of comfort levels in using the new system. To reduce these variations and improve the quality and efficiency of intake processing, the UBT set the goals of standardizing job tasks and ensuring that each team member had sufficient training and understanding of the system’s capabilities.

“Workplace safety’s  
coming over me, there  
are hazards in most  
everything I see, from the  
cords on the floor, the  
green dot upon the door,  
I remember to wear my  
PPE...”

The Home Health Care UBT penned  
a song to enliven the way in which  
staff and management approach  
workplace Safety. PPE refers to  
“personalized protective  
equipment.”

## *2 North/2 South Medical Surgical Unit: Projects and Outcomes*

The 2 North/2 South UBT was formed in October 2008. The unit includes approximately 100 employees and 224 beds. The UBT has a representative group of 11 members, including a management co-lead and two labor co-leads, both of whom are RNs and members of UNAC.<sup>48</sup>

The team has focused its work largely on improving workplace safety and quality of care. In 2009, the UBT identified a high incidence of workplace-related injuries in the unit and concluded that addressing this issue would have important implications for staff satisfaction and cost savings. The UBT subsequently developed the *workplace safety improvement project*, which aligned with two elements of the Kaiser Permanente value compass: best place to work and affordability. The team worked closely with San Diego's workplace safety consultants, who provided information on types and number of injuries, assisted in developing tools and concepts to engage staff and reduce injuries, and offered ongoing support to the team and the entire staff.

The team began by providing safety observation training for all staff—training that was previously available only for charge nurses and managers. Each staff member was then required to conduct three safety observations per week. Staff focused their observations on the department's "turn teams," which are responsible for turning patients every two hours in an effort to prevent pressure ulcers. Many staff injuries typically occur during this process. With all staff conducting safety observations, the number of observations increased dramatically from the 24 observations per month conducted by managers to 500 observations per month. "The frequency of the observations kept proper patient-handling techniques at the forefront of team members' minds," notes Jenny Button, lead UBT consultant at San Diego.<sup>49</sup>

Through the workplace safety improvement project the department also adopted the use of communication tools such as a communication tree, a board displaying progress, and a "No Injury" button which was worn during the month of July (typically the department's highest injury month). Jenny Button also notes that the team conducted a "treasure hunt" to direct staff to the storage location for each type of lift equipment used in patient handling. "The hunt provided a fun way to ensure that each person was aware of location of the equipment, so that it could be quickly located when needed," says Button.

The use of turn teams was particularly effective for decreasing worker injuries and the occurrence of patient pressure ulcers. These results were similar to the outcomes of the 5 North/South medical surgical unit, where turn teams were successfully implemented in 2009. Overall, the workplace safety improvement project at 2 North/2 South resulted in improved inpatient service and zero patient handling injuries since 2009. Furthermore, the department's

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<sup>48</sup> Some San Diego UBTs that have more than 100 members have more than one labor co-lead to help with coordination and to make sure there is good communication among the entire group. However, this is not always the case. The number of co-leads also depends on their experience, as some newer co-leads may need more support and back-up.

<sup>49</sup> Interview with Jenny Button on 4/8/11.

staff now take a proactive and positive approach to workplace safety and feel comfortable pointing out unsafe work practices to their colleagues. The UBT plans to continue to focus on workplace safety with the goal of increasing the number of days between injuries to 365 days or more.

#### *Emergency Department: Projects and Outcomes*

The Emergency Department at San Diego Medical Center has approximately 350 employees across three shifts. The department relies on two UBTs: the ED day UBT and the ED evening UBT. Both teams were formed in June 2009 and include RNs, hospital aides, and service assistants. Two key projects of these UBTs include the *communication improvement project* of the ED evening UBT and the *member service improvement project* of the ED day UBT.

The evening UBT noted that the number of department staff meetings and pre-shift and hard-copy briefings was not adequate to support the communication needs of a large, multi-shift department. This communication deficit had implications for quality of care as well as for patient and staff satisfaction. To tackle these issues, the team set goals to train the staff in the use of an electronic communication system (iNotes) and to ensure that all staff actively viewed and responded to their email. Using a communication tree and a training tracking system to support their work, the team increased the percent of staff that had access to and were trained in iNotes from 10 percent to 94 percent from May to July 2010. The percentage of staff using email increased from 10 percent to 100 percent by September 2010. Key success factors for the work of the evening UBT included the adoption of the communication tree and the use of a tracking system to keep records of staff members who have received training and have gained access to email. Next steps for the team included monitoring and sustaining email communication and using the communication tree to obtain feedback from the unit staff.

The Day UBT tackled the problem of low patient satisfaction, as indicated by *member service scores*. The UBT examined results from a department-specific survey and decided to focus on the item that scored lowest: informing patients about the length of their treatment. The UBT implemented an on-site member survey as a tool to promote communication with patients and an electronic tracking system to increase diagnostic turnaround. Thus, the team was able to increase the percent of patients indicating in their survey results that they had been informed about the length of their treatment from 63 percent to 80 percent between June and August 2010. The use of on-site member surveys and the electronic tracking system to measure diagnostic lag time were the key success factors for this project. As next steps, the team decided to permanently implement the on-site survey and increase collaboration between the two Emergency Department UBTs.

#### *Medical Center-Wide Outcomes*

As mentioned above, UBTs at San Diego are expected to achieve not only goals that are specific to their units but also goals or targets that relate to the entire medical center. Attainment of area-wide goals is linked to a performance bonus program, called the *performance sharing program*

(PSP). PSP offers a cash payout that supplements the regular pay of union employees who are in the partnership when annual performance goals are met or exceeded.<sup>50</sup> Under this program, the following variables are monitored: attendance, clinical goals, healthy workforce, inpatient care experience, outpatient care experience, and workplace safety. For most of these variables during the first four months of 2011, the San Diego medical center area was on track to reach and exceed 2010 performance scores. For example, in terms of attendance, the 2010 year-end mark for “last-minute” sick absences was an average of 3.89 days. For 2011, the minimum target was to reduce these absences to 4 days (an average of all medical center area employees) and the maximum target was to reduce them to 3 days. As of April 2011, San Diego area’s performance was at 3.77 days, exceeding the minimum target of 4 days.

Clinical goals set under PSP for San Diego and the entire Southern California region involve two main areas: 1) Controlling high blood pressure to decrease the risk of heart disease, stroke, heart failure, kidney disease, and blindness; and 2) Improving the successfully captured opportunities rate (SCOR), which consists of increasing testing rates to screen patients overdue for cervical cancer tests, blood sugar control tests, and lipid control tests. As of April 2011, San Diego was on track to reach the minimum target for high blood pressure control, and had already exceeded maximum SCOR targets set for the year.

In addition to the outcomes mentioned above, San Diego Medical Center assistant administrator Ray Hahn highlights the strong labor-management relations enjoyed at San Diego. This stability is evidenced by the absence of strikes or walkouts as well as the increased engagement of front-line staff, reflected in the increased number of UBTs from 9 teams in 2007 to the current total of 132 teams. Finally, UBT work has enabled employees to access and understand key financial and operations data, allowing for a more engaged and effective workforce.

#### *Impact of and on the Union*

An important factor for the success of the partnership in the San Diego Medical Center area has been the ability of both labor and management to learn to work together and, as expressed by Ray Hahn, to achieve stable labor relations and a positive work environment. According to Hahn, the San Diego service area operates in “an environment that fosters collaboration and partnership between labor and management. This is really the

*“The Union is there for the members. Not just for disciplinary issues, but to educate and provide them with opportunities to have a voice at work.”*

*Marianne Giordano, San Diego LMP  
co-Lead. Interview on 5/5/11.*

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<sup>50</sup> Bonuses are based on the region’s overall financial performance and the medical center area’s attainment of the PSP (performance sharing program) goals.

foundation of how we work.”<sup>51</sup> Getting to this level requires considerable effort from both labor and management. Unions have played an operative role in advising management about how to work in partnership and maintain the integrity of the collective bargaining agreement, according to LMP co-lead Marianne Giordano.<sup>52</sup> The training programs and tools mentioned above were also essential for building the partnership, as were the incentive payout programs. Through these mechanisms, union employees not only gained material benefits but were empowered to influence the way in which work was organized and performed.

Partnership has provided a new model for how labor and management can work together. Giordano states that a key positive result for both unions and Kaiser Permanente has been the focus on developing an optimal workplace for employees, providing opportunities for front-line staff to have a voice in its operation. With a positive work environment, employees can provide the best service and quality to Kaiser Permanente patients.

### *Current Challenges*

Some challenges to UBT work that persist in the San Diego medical center area include the following:

1. **Sustaining improvements:** UBT members have identified the need to develop mechanisms to sustain the improvements achieved through their work. Existing tracking systems show that there are fluctuating results obtained for the multiple variables currently monitored. One factor contributing to that fluctuation is the uneven strength of the teams in their capacity to implement partnership work. “Some UBTs have strong representative groups, and some perform better than others,” says a union representative. Another factor has to do with the nature of the work itself, which involves a high level of intensity and time pressure, in turn making it difficult for teams to stay focused on the task at hand.
2. **Operating in crisis mode:** There is a persistent tendency to focus on the “crisis of the day,” a tendency that needs to be addressed immediately, according to lead consultant Jenny Button.<sup>53</sup> This tendency may not only militate against sustaining improvements but could also stifle the expansion of the partnership.
3. **Union sponsorship:** It has been challenging for the partnership in San Diego to enlist union sponsors for the UBTs. Currently, most UBT sponsors are from management. It is difficult, union staff members report, to leave their work duties and make time for LMP

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<sup>51</sup> Interview with Ray Hahn on 3/30/11.

<sup>52</sup> Interview with Marianne Giordano on 5/5/11.

<sup>53</sup> Interview with Jenny Button on 4/8/11.

activities. Medical centers in other service areas have addressed this challenge by establishing a pool of labor sponsors who can serve the UBTs on an ad-hoc basis.<sup>54</sup> The San Diego area could benefit from the adoption of a similar system.

4. **Staff engagement and communication:** Although great progress has been made in the development of communication mechanisms such as communication trees, huddles, and email, it remains difficult to reach all staff members and continue to engage them in partnership work. At an institution that is already large, the problem is more pronounced in the largest departments and units. Insufficient union resources and the persistent tendency to operate in crisis mode make it even harder to educate and mobilize staff around partnership goals and activities.

#### **Impact of UBT and LMP Activities at San Rafael and San Diego Medical Centers**

On scrutinizing the activities and outcomes of UBTs at both San Rafael and San Diego Medical Centers, it is apparent that UBTs have had a significant impact on improvement initiatives and staff engagement, despite the challenges that each medical center faces. UBTs, with the strong support of both labor and management sponsors, have tapped the knowledge of front-line staff to introduce projects that are aligned with Kaiser Permanente's LMP goals (principally, improving quality of care and cost-effectiveness, and putting the patient at the center of all initiatives). Furthermore, they have fulfilled one of the original purposes of the LMP: improved labor-management relations. As managers, union representatives, and staff remark, the atmosphere at Kaiser Permanente is largely one of collaboration and mutual respect as opposed to one of traditional labor-management antagonism.

At the local level, UBT activities have fostered the sharing of ideas between and across departments, contributing significantly to improvement efforts at individual facilities and across regions. Co-leads have ample opportunity to visit other facilities to learn about best practices and to institute those practices at their home facility. In addition, UBTs share their projects internally through the use of the UBT tracker, which is accessible by all teams operating within the same region. Monthly co-lead meetings and interactions with senior UBT consultants at each facility provide additional opportunities for project- and information-sharing.

Medical centers have been given considerable autonomy to develop unique approaches to solving problems and structuring partnership relationships. On the one hand, this ability to function autonomously has furthered encouraged innovation and creativity. On the other hand, it has created considerable inconsistency across medical centers. As José Simoes notes, the success of UBT initiatives often depends on local conditions. Still, unions have an opportunity to

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<sup>54</sup> "Taking a dip into the labor sponsor pool," Kaiser Permanente Labor Management Partnership, <http://www.lmpartnership.org/>.

determine how they can best support high-functioning UBTs and help medical centers export successful processes to other sites.<sup>55</sup>

Besides encouraging unions to become a conduit for the diffusion of best practices, the LMP process and the Coalition of Kaiser Permanente Unions have encouraged unions to think about building their internal capacity in a nontraditional way. Partnership work has helped the unions evolve alongside management to be able to function effectively in a partnering environment. “The more you invest in [UBT work], the less you have to do on a traditional union level,” adds José Simoes. There have been challenges along the way, of course, but “you cannot argue with the results,” he says.<sup>56</sup>

## **FLETCHER ALLEN HEALTH CARE: MODEL UNIT PROCESS**

### **Overview**

Fletcher Allen Health Care is an academic medical center in Burlington, Vermont that serves as the teaching hospital for the University of Vermont and as a community hospital for the area’s residents. Its four facilities at the Medical Center Hospital of Vermont, Fanny Allen Hospital, University Health Center, and the University of Vermont’s College of Medicine house 562 licensed beds. These facilities along with Fletcher Allen’s 30 outpatient sites and community clinics serve roughly 50,400 patients per year and employ 6,700 staff members. Of these, 450 are University of Vermont medical group physicians, 147 are advanced practice registered nurses/physicians’ assistants, and more than 1,650 are registered nurses.

The establishment of *model unit process* (MUP) activities at Fletcher Allen in 2006 is inextricably tied to the creation of the Vermont Federation of Nurses and Health Professionals (VFNHP) Local 5221, a local union comprised of LPNs and RNs that is affiliated with the American Federation of Teachers (AFT). VFNHP is currently the only labor union present at Fletcher Allen. When it came into existence as a bargaining unit in 2003, the nurses it represented were largely concerned with securing appropriate staffing ratios for the hospital. In Article 20 of the first contract between VFNHP and Fletcher Allen signed in 2003, both the union and the hospital agreed that “staffing the Hospital with the appropriate number of skilled, reliable nursing employees is an essential element for the provision of quality patient care.”<sup>57</sup> To ensure adequate staffing, then, the contract established a staffing committee, to be composed of

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<sup>55</sup> Interview with José Simoes on 6/28/11.

<sup>56</sup> Ibid.

<sup>57</sup> Article 20, 2003-2006 VFNHP and Fletcher Allen Health Care collective bargaining agreement.

three bargaining unit employees chosen by the union and three nursing administrators chosen by Fletcher Allen. This team would develop a staffing plan and a budget “consistent with staffing ratios approved by national nursing specialty groups as well as findings from national nursing research regarding nurse staffing and patient outcomes.”<sup>58</sup>

In 2006 VFNHP documented that Fletcher Allen had not adhered to the staffing ratio provisions set forth in the 2003 contract. After several meetings with management to resolve these issues, the union filed a grievance on behalf of its members. The hospital claimed that there was no justification for the grievance, stating that they were in compliance with the contract. Unable to resolve the grievance, the union filed for arbitration. After extensive meetings with the arbitrator, VFNHP withdrew its grievance, deciding that it would be more effective for all concerned to establish a problem-solving process that would improve quality of care and patient safety. Jennifer Henry, the president of the union at this time, convinced management and VFNHP’s Executive Committee to establish an innovative process whereby nurses and unit managers would meet to analyze the needs of patients and determine appropriate staffing levels by unit. This agreement became a sidebar amendment to the contract (Article 20A), establishing the model unit process (MUP).

MUP activities have enabled nurses to become involved not only in determining appropriate staffing levels but also in influencing the way in which units function at Fletcher Allen through the redesign of care delivery and work processes. The MUP was formally written into the 2009-2011 collective bargaining agreement between VFNHP and Fletcher Allen “with the intent of creating a collaborative culture, reducing financial impact, and building a systems-wide approach to quality improvement.”<sup>59</sup>

This section will detail the structure and goals of MUP activities at Fletcher Allen. In addition, it will describe the outcomes and challenges of MUP work at the hospital by examining the experience of three units. Particular attention will be paid to the clinical outcomes influenced by MUP activities and to the impact on the union of participating in this joint labor-management process.

### **Structure and Goals of the Model Unit Process**

The inspiration for the MUP originated in a visit that Jennifer Henry, past president of VFNHP Local 5221, made to Sunnyside Medical Center, a Kaiser Permanente facility in Clackamas, Oregon in late 2005, well before the staffing ratio arbitration was resolved. Energized by the partnership work that was taking place at Sunnyside, Henry returned to Fletcher Allen inspired to institute a similar joint labor-management process there. Henry envisioned that such an initiative would bring about a “culture change” that promised to be far more effective than relying on

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<sup>58</sup> Article 20, 2003-2006 VFNHP and Fletcher Allen Health Care collective bargaining agreement.

<sup>59</sup> Article 20B, 2009-2011 VFNHP and Fletcher Allen Health Care collective bargaining agreement.



arbitration to solve disputes.<sup>60</sup> For Henry, the labor-management partnership approach had the potential to strengthen the local union by involving its members in an intensive process of work redesign—a process that would rely on their expertise and insight.

Henry's solution was innovative but high-risk. There was skepticism on the part of hospital administrators and the union executive committee alike as to the viability of MUPs. In particular, some VFNHP executive committee members had clear doubts as to whether MUPs would result in improved staffing levels and provide nurses with opportunities to solve patient and workflow issues. Nevertheless, Henry was ultimately successful in convincing the hospital and the union executive committee to drop the arbitration case and to accept a revised approach to establishing staffing ratios as set forth in Article 20A.

Since their introduction in 2006, the structure, content, and scope of MUP activities have changed significantly. In the first three training cycles of MUPs (referred to as “waves”) from 2005 until 2008, four units were selected to undergo the process, and each was paired with its own MUP facilitator. Teams would work separately, and there was not a great deal of collaboration between units. Furthermore, the teams were asked to examine all the major functions of their units and then determine the areas for which they would develop interventions. At the end of the cycle, each MUP team shared its recommendations with others on the unit to get their approval. Additionally, the president of VFNHP and the chief nursing officer of Fletcher Allen were required to sign off on MUP recommendations regarding issues of staffing, budget, and any related collective bargaining matter before these could be implemented. This approach gave teams a remarkable amount of freedom to address any problems they identified on their units. Along the way, the teams developed unique sets of metrics to track the progress of their improvement initiatives. However, the process tended to be unfocused and inconsistent, making it difficult for teams to finalize their recommendations and come to an agreement with the hospital.<sup>61</sup>

The MUP structure and process shifted significantly in 2008 to an emphasis on giving nurses the specific tools and techniques they would need to implement change on their units and build a more collaborative culture throughout the hospital. Secondary goals were to expand the ability of MUP teams to learn from each other, develop an infrastructure to support quality improvement activities, and reduce the time needed for training. To this end, Fletcher Allen and VFNHP agreed to continue the MUP initiative using one consultant—currently, Bonnie Walker of the Tupelo Group.

Since 2008, the MUP has used the following format: Four units are chosen to meet seven times in day-long sessions for a period of six months. Of these seven meetings, five are “learning

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<sup>60</sup> Interview with Jennifer Henry on 4/27/11.

<sup>61</sup> Ibid.

sessions” organized to provide training, access to patient care and budgetary information, and time to develop and test recommendations. The remaining two sessions include a kick-off orientation session and an *Outcomes Congress*, scheduled a few months after the completion of the final learning session. The Outcomes Congress gives teams an opportunity to share their experiences and recommendations with other union and hospital leaders as well as staff from other areas of the hospital. All training sessions are facilitated by Bonnie Walker, the external consultant. Additionally, one or two union coordinators and the director of nursing attend all learning sessions. Other healthcare professionals (including physicians) attend work sessions on an as-needed basis, and the union is available between learning sessions for consultation.

Each MUP team consists of the following staff members: one director, one nurse manager, one nurse from each shift or unit location, and one nurse educator. These team members are elected by their co-workers and are responsible for representing their unit. Team members communicate with the nursing staff on their unit throughout the process, using tools such as communication trees (similar to the tools used at Kaiser Permanente), a physical communication area (such as a corkboard in the department’s break room), surveys, and guest presentations at MUP team meetings. The team also routinely solicits ideas and feedback from the unit as a whole. During training and planning meetings, all four teams work and learn together in the same room—another mechanism for enhancing communication between teams. Bonnie Walker encourages teams to “steal shamelessly from each other” and links up teams working on similar problems.

The current goals of the MUP are to build a collaborative culture in each unit of the hospital, spread that culture to outpatient clinics, and ultimately to build a system-wide approach to quality improvement. The key tools that MUP team members use to make change on their units include: the *relationship-based care* model for improving the patient experience, the common quality improvement approach of “Plan, Do, Study, Act” to establish a flexible change process, and the concept of *clinical microsystems* to target specific improvement efforts.<sup>62</sup> Teams also use online tools such as a shared drive for disseminating templates.

MUP teams are asked to focus on specific areas of improvement. They are urged to tackle two system-wide issues by choosing projects related to infection prevention and communication, and two specific unit-based issues. In addition, teams identify “low-hanging fruit”—easily surmountable problems on the unit that have caused workarounds, clinical errors, and staff dissatisfaction. To provide further focus, all staff members from their respective units are asked to fill out a survey to identify key problem areas before the MUP cycle begins.<sup>63</sup> Additional data regarding patient satisfaction, staff satisfaction, nursing quality indicators measured by National

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<sup>62</sup> In order to enliven and make real the concept of relationship-based care, each team was asked to choose a symbol such as a doll or a pillow that would represent the patient and their family. These symbols would be brought to every meeting and would serve to remind team members of their goals to improve patient care.

<sup>63</sup> See Appendix C.

Data Quality Indicators (NDQI), other unit-specific surveys, and external research are also gathered at the start of and during the MUP cycle. MUP team members use information extracted from these varied sources to help them choose the quality improvement projects that will be most relevant to unit needs and to national quality standards.

Each MUP cycle is a six-month process. Once MUP team members come up with solutions, the unit's *professional practice council* (PPC), which is similarly comprised of nurses and nurse managers, is responsible for implementing and sustaining the changes.<sup>64</sup> The PPC is a permanent group whose configuration and roles differ by unit.

The following section will discuss in more specific detail the projects and experiences of three units during Wave 5 of MUP activities: Baird 3 (Orthopedic and Urology Surgical Unit), the Fanny Allen Operating Room, and Inpatient Psychiatry.

### **Model Unit Process Activities**

#### *Baird 3 (Orthopedic and Urology Surgical Unit): Projects and Outcomes*

Baird 3 is an Orthopedic and Urology Surgical Unit that consists of 29 patient beds and a staff of 41 nurses, 16 Licensed Nursing Assistants (LNAs), and 3 secretaries. As of November 2010, the unit has an average daily census of 23 patients, who receive care on the unit for roughly 3-4 days.

As were all teams during wave 5 of MUP, Baird 3 was asked to concentrate on developing projects to improve communication, infection control, and two unit-specific issues. At the time, there was palpable tension between Baird 3 and the Post-Anesthesia Care Unit (PACU) staff, along with unsafe patient transfers to the PACU and lack of time for nurses to complete the admission process to the PACU. Consequently, Baird 3 decided to focus its communication improvement efforts on relations between Baird 3 and the PACU and the achievement of an 85 percent complete PACU admission rate. The team diagrammed the admission process and used data collected from the first *core unit process survey* and the PACU satisfaction survey, along with other sources, to develop possible solutions to the communication gap. Ultimately, the team decided to test the pairing of Baird 3 and PACU nurses, daily rounding and real-time communication between the Baird 3 and PACU charge nurse, and a LNA responsible for handling admissions to the PACU. The unit is still testing the efficacy of these suggestions.

In addition to improving communication with the PACU, Baird 3 chose to focus on reducing its patient fall rate to 2 falls per 1,000 patient days. Before the start of the MUP initiative, the unit's fall rate in 2010 was 3.07 falls per 1,000 patient days, which was above the Fletcher Allen target fall rate. In order to reduce falls in the unit, the MUP team implemented the following changes: use of bed alarms according to policy for all patients, LNA and RN alternating hourly rounds,

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<sup>64</sup> At the time of publication in November 2011, VFNHP was in the process of restructuring the organization and composition of the PPCs and other nursing councils at Fletcher Allen.

charge nurse responsibilities to include the printing of a list of fall risk patients and monitoring these patients' use of bed alarms, and posting a list of fall-free days in the nurses' station to keep staff focused on preventing falls. At the end of the process, the team recommended that the unit continue the new roles and activities listed above. Baird 3 also joined Fletcher Allen's Medical/Surgery unit falls group. The unit's practice council will continue to review fall rates at its monthly meetings and discuss its sustained approach to fall prevention. Baird 3 falls data collected during the MUP period indicates that the unit was able to attain a fall rate of 2 falls per 1,000 patient days in January and February 2011.

One significant challenge faced by the Baird 3 team throughout the MUP cycle involved finding ways to foster communication and participation by unit nursing staff members not already on the team. Members of the Baird 3 team note that their use of available communication tools did not generate enthusiasm for MUP projects. Staff were busy, skeptical of change, and did not have a clear understanding of the purpose of MUP activities. The team also remarked that it would have been more profitable for them to go through the MUP cycle at the same time as the PACU or other medical/surgery units. Being grouped with comparable units might have yielded deeper collaboration and greater insights into unit improvements. Despite these setbacks, the Baird 3 team believes that the MUP cycle was enriching and provided "eye-opening" information about how change is made at the unit level.

#### *Fanny Allen Operating Room: Projects and Outcomes*

The Fanny Allen Operating Room (OR) is a five-room outpatient surgery center with two minor procedure rooms. The OR sees 25-40 elective and non-urgent trauma cases per day, generally for orthopedic, eye, dental and general surgical care. The unit employs 29 staff members and has an extremely high retention rate.

Because the unit does not actively contend with infection control problems, the Fanny Allen OR MUP team decided to focus its designated infection control project on sustaining normothermia, the maintenance of a patient's temperature equal to or above 36 degrees centigrade upon their arrival in the Post-Anesthesia Care Unit (PACU). The team analyzed Medicare reimbursement data, which indicated that patients who are warmer during their surgery spend less time in the hospital, as sustained normothermia promotes healing and reduces surgical site infections. To promote normothermia, the MUP team decided to introduce thermalite hats and warming blankets, and to study the difference in patient body temperature with these additions. It turns out that the use of the hats and blankets helped maintain patients' body temperature at or beyond the requisite level, and the team plans to continue their use on the unit.

As noted above, in many cases a unit's PPC is responsible for monitoring and tracking the activities implemented by the MUP team. In the case of the Fanny Allen OR, however, the unit did not have a pre-existing PPC. The MUP team decided that, in order to establish a consistent means of communication for unit staff and to facilitate the continuation of work begun during the

MUP cycle, they would develop the infrastructure for a unit PPC. To this end, the team suggested that the PPC have bi-weekly meetings; be staffed by two RNs, one scrub technician, a nurse educator, a nurse manager, and a nurse director; and include one member who had been a MUP participant.

The lack of a PPC in the Fanny Allen OR points to one of the larger current challenges to MUPs. As will be discussed in the current challenges section, there is little accountability for follow-up work to MUP activities. With no explicit handoff between the unit PPC and the MUP team, and with non-operational PPCs in some units, an accountability gap persists. Nevertheless, MUPs provided the Fanny Allen OR with the opportunity to think about how to sustain quality, communication, and work process improvement on the unit and the chance to engage nursing staff members in this work.

#### *Inpatient Psychiatry: Projects and Outcomes*

The Inpatient Psychiatry unit consists of 28 patient beds spread across two floors and admits 700-800 patients per year.

For its infection control project, the Inpatient Psychiatry MUP team tackled a nationwide issue that had particular resonance on their unit: bedbug infestation. Inpatient psychiatry patients are a population specifically at risk for introducing bedbugs into the hospital. Further, surveys revealed that inpatient psychiatry staff were dissatisfied with the process of handling patients' belongings on the unit. The team reviewed that process and made the following alterations: patients' belongings would be bagged and stored on the unit; patients would be screened for bedbug exposure; social workers

### The Financial Impact of Nursing Turnover

It is well known that nursing is a difficult and demanding profession. General pressures of work life along with organizational specifics cause nurses to leave their place of employment. KPMG's 2011 U.S. Hospital Nursing Labor Cost Study reports that its diverse sample of 120 hospitals faces an annual nursing turnover rate of 14%. According to another 2011 study by Nursing Solutions, Inc., 27% of nurses terminate their employment contract with less than a year of service.

For each percentage point increase in annual nursing turnover, a healthcare organization loses roughly \$300,000 (Success Factors Inc., 2009), as the organization is forced to make expenditures to hire and train a new nurse while quality of care erodes due to staff shortages and change.

As the case of Fletcher Allen illustrates, nurse turnover can be diminished by involving nurses in developing clinical processes and determining safe staffing ratios. A work environment that is responsive to nurses' needs and respectful of their input is one that nurses are less likely to leave.

would alert patients of the need to bring their belongings in plastic bags and to pack no more than three changes of clothes; and belongings would be searched in a designated non-carpeted area. These measures exceed Fletcher Allen's current bedbug prevention policy, and the unit's PPC has continued to implement all recommended changes since the conclusion of the MUP cycle.

Members of the inpatient psychiatry team also looked to the results of their core process survey, which was completed before the MUP wave began. They found that nurses were dissatisfied with the way in which multidisciplinary rounds were being conducted on Inpatient Psychiatry's two floors. Communication breakdown between shifts, excessive time spent on rounds, and lack of awareness of all aspects of a patient's care progress were impacting continuity of care, communication, and effective discharge planning on the unit. The team then collaborated with business students from the University of Vermont, who visited the unit to study the multidisciplinary rounds process and make recommendations as to how it could be streamlined. Using the study conducted by the business students and their own input, the inpatient psychiatry MUP team changed the process so that nurses would attend rounds for specific patients and a clinical nurse specialist would consult on complex patients after the rounds meeting. The team also recommended a trial elimination of the traditionally used rounds communication book to encourage nurses to speak with each other in person during the rounds meeting.

The Inpatient Psychiatry team's work to restructure multidisciplinary rounds highlights the potential impact of a labor-management partnership, even when it is primarily intended for nurses and nurse managers, on all staff members in a unit. The new approach to multidisciplinary rounds "really broke the system for all of the staff on the unit," says Lauren Tronsgard-Scott (manager, Inpatient Psychiatry), and nurses are refusing to return to the old model. As is evident here, partnership has the potential to transform the way that staff members communicate and work together, especially when physicians and specialists collaborate with nurses and other front-line staff.<sup>65</sup>

### *Hospital-Wide Outcomes*

The unionization of Fletcher Allen's nurses in 2003 and the establishment of MUPs in 2006 have combined to make a significant impact on nurse staffing ratios and turnover. Before VFNHP organized a bargaining unit and later drove the creation of a labor-management partnership, working conditions for nurses at Fletcher Allen were unfavorable.<sup>66</sup> Many local nurses chose to travel to far-flung hospitals rather than work at Fletcher Allen, which left 225 nursing positions open in 2006. Turnover was high as new nurses quickly left the hospital to seek employment elsewhere. In addition, the hospital consistently relied on the use of "travel nurses," non-local nurses who travel to a location for temporary, short-term employment. Hiring such nurses is

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<sup>65</sup> Interview with Lauren Tronsgard-Scott on 4/27/11.

<sup>66</sup> Interview with Jennifer Henry on 4/27/11.

costly and creates inconsistencies for healthcare organizations. In 2006, Fletcher Allen employed at least 125 travelers.

The MUP teams pursued new ways of giving nurses a voice in the workplace and made specific changes to work environment and clinical practices. As a result, conditions at Fletcher Allen began to improve. At the time of publication, no travelers have been hired, open positions remain limited, and the hospital boasts a low nursing turnover rate.

MUP work has been able to transform working conditions for nurses at Fletcher Allen by aligning unit-based and hospital-wide quality improvement initiatives. All teams bear responsibility for addressing issues that are specific to their unit alongside those that are hospital-wide, such as infection control and communication. In a short period of time, the MUP teams quickly removed barriers to high-quality care and solved easy-to-fix problems—the “low-hanging fruit” approach—at the workplace, making it safer and more effective for patients and staff alike. These early victories have energized MUP team members and unit nursing staff to make deeper changes guided by MUP goals.

### **Impact of and on the Union**

Two major factors, both generated by the union, compelled the hospital to agree to undertake collaborative labor-management work: VFNHP’s commitment to securing appropriate staffing ratios; and the union’s creative reaction to the hospital’s unsatisfactory compliance with the 2003-2006 collective bargaining agreement. The union has continued to have a strong presence throughout the MUP period thus far. As mentioned above, VFNHP representatives serve as coaches for the teams, providing them access to union input when needed and answering questions in terms of roles, responsibilities, and accountability. Although the MUPs represent a joint effort between VFNHP, Fletcher Allen hospital administration, nurse managers, and nurses, it is clear that the union has contributed a considerable amount of time, resources, and leadership support to ensure that the activities are successful and productive for team members.<sup>67</sup>

MUP activities have also had a positive impact on the union and have empowered union members to participate actively in work process improvement activities. Through MUPs, nurses gain access to department budgets, enabling them to make informed decisions and to understand what it takes to run a department from a manager’s perspective. Nurses and their managers are also appreciative of the opportunity to get to know each other better while working together to tackle and resolve big and small problems on their units.

From a union-building perspective, MUP work has been a conduit to instituting appropriate staffing levels in many departments throughout Fletcher Allen. As mentioned previously, there are no longer traveling nurses at the hospital, and there are a reduced number of open position postings. Union membership has increased by 12 percent since the inception of the MUP process

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<sup>67</sup> The union pays for half of the external consultant’s costs for training and coaching activities.

and, perhaps more importantly, members' morale has risen significantly.

### **Current Challenges**

MUP activities have allowed nurses to address significant problems related to staffing ratios, workflow processes, and clinical procedures in their units while building a reflective, collaborative environment for nurses and nurse managers. Nevertheless, there are a variety of challenges to MUP work that diminish the effectiveness of the process for hospital staff, the union, and Fletcher Allen as a whole.

1. **Limited scope of teamwork:** MUPs have created a venue for collaboration and teamwork between nurse managers and nurses at Fletcher Allen. Unit teams may also invite a physician or other healthcare professional to sit in on their meetings or to offer advice and support. However, beyond this infrequent inclusion of physicians, an invitation to participate in collaborative efforts is rarely extended to other healthcare professionals who work alongside nurses at Fletcher Allen. Because the MUP initiative is part of the union's current collective bargaining agreement with the hospital, management has been reluctant to expand the process in its current form to include other front-line staff and managers. The hospital honors the contract but has not attempted to use the MUP process to bring together all healthcare providers on a regular basis. To deepen the quality improvement work and collaborative environment fostered by MUP activities, it will be important to find ways to include other front-line staff members and managers or to solicit their input and knowledge of work processes on a more consistent basis.
2. **Sustaining work:** Over the course of the MUP cycle, each unit's team researches and tests ways to make improvements to quality of care and the workplace environment. The MUP cycle culminates in a presentation, during which the team makes formal recommendations to the department for approval by the president of the union and director of nursing. But because the MUP process is only temporary, there is a widespread problem of a lack of follow-up to ensure that agreed-on recommendations are implemented and sustained. In theory, the unit's nursing professional practice council (PPC) is responsible for following up on MUP recommendations and tracking their implementation. Some PPCs have embraced this handoff and have established a process to monitor recommendations while establishing continuous quality improvement activities. Still, many PPCs have not focused on these important tasks. In addition, some PPCs meet only erratically, if at all. Overall, there is no clear process for sustaining initial MUP activities and expanding quality improvement through the PPCs.
3. **Poor documentation:** Documentation and tracking of the impact of initial MUP recommendations continues to be weak and, in many cases, nonexistent. No complete list of the units that have undergone the MUP process is readily accessible, nor are the results



of MUP work known to others in Fletcher Allen's hospital and clinics. Similarly, there is no centralized repository for cataloging the changes that MUPs teams have established in their departments or for the agreements signed by the union and the Fletcher Allen administration. Several teams have still not completed their recommendations for final approval, and there does not seem to be any sense of urgency for them to do so.

4. **Limited staff orientation, education, and communication:** Many nurses who have been through the MUP process commented that their orientation, education about its purpose, and communication during the process were inadequate. First, before beginning MUP activities, each unit is asked to fill out a core process survey, which is later used to guide the improvement projects developed by the MUP teams. Some MUP team members commented that they were unaware of the purpose of the core process survey when they were filling it out. Therefore, the survey was less useful to them as they attempted to develop projects tailored to the needs of their unit. MUP team members suggested that the team or unit be allowed to edit the core process survey before it is administered to be able to contribute unit-specific questions and eliminate irrelevant ones. In this way, they would stand to gain the most actionable knowledge from the results of the survey. Second, some team members noted that they did not have significant knowledge about what the MUP process would look like and what the responsibilities would be for MUP team members. This has made it difficult at times to recruit nurses for MUP teams. As well, a lack of information has affected unit nurses who were not members of a MUP team but were expected to contribute their knowledge and insight to the MUP process. Some teams remarked that this lack of knowledge of the goals, roles, and opportunities for MUP team members made it difficult to engage with unit nurses during their unit's MUP sessions, as these nurses did not fully understand what was taking place.
5. **Lack of hospital-wide communication:** While VFNHP and Fletcher Allen have committed significant resources to train and support MUP activities, neither the hospital nor the union appears to have established ongoing methods to promote the work and specific outcomes of MUPs. At Fletcher Allen communication about MUP outcomes is weak, and it is difficult to obtain information about the real accomplishments of various MUPs cycles. It is also unclear how informed the hospital administration is about these outcomes. As for the union, VFNHP is aware of MUP activities, which are mentioned occasionally in the union newsletter. However, several union activists stated that the development and outcomes of MUP activities are not shared on a regular basis at union membership and board meetings, although there has been an increased push to do so. If the outcomes and use of MUPs were more actively shared and celebrated in the hospital by both union and management leaders, nurses and their managers might feel that their efforts had greater value. In addition, new units entering the MUP process would perhaps

be more motivated to embark on a team-building and quality improvement journey that is strongly endorsed by both their union and hospital.

### **Conclusion**

The institution of MUP activities at Fletcher Allen Health Care is a testament to VFNHP's ability to devise a creative solution to resolve a staffing arbitration. MUPs at Fletcher Allen have provided nurses with a voice in problem-solving at the unit level, as well as access to traditionally hard-to-obtain information around departmental budgets, patient satisfaction scores, and safe staffing levels.

The MUP has provided nurses and nurse managers with concrete tools and skills to make meaningful improvements to work flow processes and clinical procedures on their units. Despite problems with documentation and hand-offs to the unit's professional practice council, the MUP process continues to grow, evolve, and provide VFNHP with a powerful platform through which to engage its members.

## **MONTEFIORE MEDICAL CENTER: CMO, THE CARE MANAGEMENT COMPANY**

### **Background**

From a healthcare perspective, the borough of the Bronx, NY, is home to one of the most challenging populations in the United States. With approximately 1.4 million residents, 80 percent identify as either Black or Hispanic, and more than 30 percent subsist below the poverty line.<sup>68</sup> Bronx residents contend with increased instances of chronic disease such as diabetes and hypertension, higher mortality rates, and poorer health outcomes associated with disadvantaged socioeconomic status. Consequently, they rely heavily on government-funded health insurance to cover their complex care needs.

Montefiore Medical Center, the university hospital for the Albert Einstein College of Medicine, serves the population of the Bronx and Southern Westchester at various locations throughout the area with its three general hospitals, a children's hospital, 21 outpatient medical group sites, an acute rehabilitation unit, and a home health agency.<sup>69</sup> Montefiore's mission is "to heal, to teach, to discover and to advance the health of the communities [it] serve[s]." The medical center has a

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<sup>68</sup> City-Data, <http://www.city-data.com/city/Bronx-New-York.html>.

<sup>69</sup> Spencer Foreman, "Montefiore Medical Center in the Bronx, New York: Improving Health in an Urban Community," *Academic Medicine* 79, no. 12 (2004): 1155.

longstanding commitment to providing integrated, community-centric healthcare services that extend beyond the traditional purview of most academic medical centers.<sup>70</sup>

In addition to its progressive social mission, Montefiore's approach to labor-management relations is also innovative. In 1959, the Service Employees International Union Local 1199 (1199/SEIU) organized and won recognition for the union at Montefiore. The medical center is also a member of the League of Voluntary Hospitals and Homes of New York (LVHH), the bargaining agent created in 1968 for medical centers, hospitals, and nursing homes in the New York metropolitan area. As a member of LVHH, Montefiore is engaged in the labor-management partnership initiatives of the League and with 1199/SEIU. Montefiore was the first New York City medical center to grant recognition to unions voluntarily, and union officials have praised Montefiore's leadership for its commitment to labor-management partnership.<sup>71</sup>

Over 15 years ago, as part of its efforts to offer more comprehensive care, chronic disease management services, and now behavioral health services, Montefiore organized its physician network into an Integrated Provider Association (IPA) for the purpose of entering into financial risk (capitation) contracts with managed care plans.<sup>72</sup> They similarly arranged their psychiatrists and psychologists into an analogous group known as Montefiore Behavioral Care Independent Provider Association (MBCIPA). At the same time, CMO, The Care Management Company was created as a subsidiary of Montefiore to provide administrative support to the IPA and MBCIPA in the form of customer service, contracting, provider relations, credentialing, claims payment, financial management, data analysis, care management, and reporting. CMO was also designated to manage capitated contracts with the IPA and MBCIPA, healthcare institutions, and managed care plans. Currently, Montefiore along with its IPA and MBCIPA have capitation contracts covering all

"Montefiore views service to the community as one of its cardinal commitments and explicitly names it with patient care, education, and research as the fourth tenet of its mission."

Spencer Foreman

"Montefiore Medical Center in the Bronx, New York: Improving Health in an Urban Community." *Academic Medicine* 79.12 (2004): 1154-1161.

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<sup>70</sup> Montefiore Medical Center, <http://www.montefiore.org/whoweare/vision/>.

<sup>71</sup> *PRNewswire-USNewswire*, "Steven M. Safyer, MD, Appointed President and CEO of Montefiore Medical Center," November 27, 2007; *American Rights At Work*, "The Labor Day List: Partnerships that Work," 2007 Edition.

<sup>72</sup> Capitation refers to a method of paying for healthcare services in which a fixed amount of premium dollars per designated period of time is given to healthcare providers to cover care expenses for an individual regardless of whether that individual accesses those services or not.

lines of business including Medicare, Medicaid, and commercial plans that cover close to 150,000 individuals and generate an associated \$750M in capitation payments.

CMO's business model focuses not on generating revenue but rather on developing seamless managed care for patients with capitated insurance policies. This model, though at times financially precarious, allows CMO to impact the health of individual patients who are often struggling with the complications of chronic disease and the public health challenges of the Bronx community at large.

The format of this case study will deviate slightly from the three previous examples of San Rafael, San Diego, and Fletcher Allen. It will begin with a summary of the basic structure and core functions of CMO. It will then provide an in-depth analysis of the activities of the Contact Center—the department with the most active labor-management partnership at CMO. This analysis will focus on the specific roles of the unionized workforce in the Contact Center and their involvement in quality improvement initiatives.

### **Brief History of CMO, The Care Management Company**

Montefiore's interest in managed care stemmed from a confluence of factors that affected the operational stability of the medical center from the 1960s to the 1990s. As mentioned above, the Bronx is home to a largely minority, poor, and disproportionately disease-burdened population. Given the medical and psychosocial complexity of the patient population coupled with a poor payer mix, the Bronx was a difficult place for physicians to build a successful practice. Physicians began to leave the Bronx in the 1960s in search of more lucrative practices and by the 1980s, the borough had essentially reached a crisis point in terms of adequate physician supply.

In addition to the “physician drain” from the borough, Montefiore witnessed a changing economy in the early 1990s that challenged the financial security of the medical center. The revenue generated by the hospital no longer covered its expenses, and there was significant management turnover. It was clear that Medicare and Medicaid payments would continue to erode due to declines in reimbursements from these large government programs. Montefiore was in need of a model for providing care that would promote growth in market share, reduce of the loss of patients to hospitals outside the Bronx, and allow the medical center to staff top doctors, scientists, and other professionals to support its mission as a top-flight academic medical center.

The national rise of health maintenance organizations (HMOs) in the 1990s and the medical center's perilous financial situation led Montefiore to consider a managed care approach to combat the loss of physicians and decreased revenue stream. The ideology behind HMOs, which stresses the importance of the primary care physician as a director of patient care, resonated with Montefiore's social justice and community action value system. As past Montefiore president Spencer Foreman notes, the medical center “has a long history of taking services beyond its own walls and creating programs that go beyond the traditional medical mission. Montefiore views

service to the community as one of its cardinal commitments and explicitly names it with patient care, education, and research as the fourth tenet of its mission.”<sup>73</sup>

With both economic and social justice elements as motivating factors, Montefiore created the Integrated Provider Association (IPA) and Montefiore Behavioral Care Independent Provider Association (MBCIPA) in 1995. The IPA includes physicians employed by the hospital along with many community-based physicians while the MBCIPA includes psychologist and psychiatrists in a parallel organization. Insurance companies contract with the IPA and MBCIPA to provide a certain dollar amount per member per month to pay for services provided to each member by the IPA and MBCIPA. This process is referred to as “accepting financial risk” for the provision of patient care.

CMO, The Care Management Company was established shortly after the IPA and MBCIPA in 1996 as a wholly owned subsidiary of the medical center. CMO contracts with healthcare insurance companies to manage the financial risk accepted by the IPA and MBCIPA. Put simply, CMO is responsible for ensuring that patients receive appropriate care using the premium dollars provided by insurance companies. In its earliest stages, CMO served 40,000 members. In 2000, CMO entered into an agreement with HIP (now known as Emblem) to add 100,000 lives to the care management system, elevating the total number of captured lives to 150,000.

CMO has since maintained its profile of 150,000 lives through contracts with Emblem, Oxford Health, and Health First. As of 2011, CMO generates \$750 million per year in premium revenue that is subsequently invested into the care of its members. CMO is now not only a viable and non-traditionally profitable entity but also allows for local providers to assert control over managing the care of the population they serve, engendering both cost savings and improved health outcomes in the Bronx.

### **Labor-Management Partnership at the Contact Center**

The Contact Center is housed in CMO’s executive offices located in Yonkers, New York, and employs roughly 100 staff members who are represented by 1199/SEIU, making it the most heavily unionized area in the entire CMO. The Contact Center provides centralized customer service support to CMO and Montefiore by handling member inquiries regarding billing, scheduling of appointments, and physician referrals. Labor-management partnership and union participation have been essential to the development of the Contact Center, its organizational structure, and the career advancement opportunities it offers its staff.

Before the IPA entered into a risk-sharing agreement with HIP in 2000, customer services at Montefiore were divided into two telephone centers: the first was referred to as “member services,” which employed six to seven representatives and typically dealt with calls from healthcare providers’ offices concerning claims. The second was a physician referral center that

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<sup>73</sup> Foreman (2004), p. 1155.

reported to Provider Services. When CMO signed a contract with HIP, the two telephone centers were combined into a single center, to be known as the Contact Center. Its staff was expanded to 20 “customer service liaisons” (a newly defined position with a new title), the majority of whom were internal hires.<sup>74</sup>

Since the growth of the Contact Center in 2000, there has been a strong commitment to labor-management partnership as evidenced by the increase of good union jobs available at the Contact Center.<sup>75</sup> Montefiore entered negotiations with 1199/SEIU in order to have all customer service liaisons represented by the local union, and the department has grown to employ roughly 100 staff members. Currently, four customer service liaison delegates facilitate dialogue between 1199/SEIU and the Contact Center and are empowered to organize monthly labor-management meetings, which are also attended by supervisors, staff, and the union organizer when schedules permit.

In addition to creating good union jobs through partnership, both 1199/SEIU and Director of Customer Services Stephen Kulovits aimed to cultivate a work environment where staff members felt engaged, motivated, and respected. Together, 1199/SEIU and management worked to develop “shared values” for the department, premised on seven keywords and phrases: trust, relationships, integrity, respect and compassion, “the golden rule,” patience, and humility.

Labor-management partnership at the Contact Center also led to the development of a career ladder and non-punitive promotional strategy. The career ladder consists of three level moves (from level I to III) that are tied to a customer service liaison’s skills, knowledge of the functions of the department, and knowledge of the functions of CMO, Montefiore and IPA overall. Employees also have the opportunity to return to a lower level after they have been promoted if they so choose, or if they cannot maintain the skills necessary to remain at a higher level. The progressive structure of the Contact Center’s career ladder ensures that all customer service liaisons “have an opportunity for career growth through [the department’s] level move process...In this way [the department strives] to create an environment of opportunity, success and growth for all associates.”<sup>76</sup>

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<sup>74</sup> A second expansion occurred around 2002 when the Contact Center began to handle patient billing inquiries in a centralized fashion. CMO then used the Contact Center to help administration understand the scope of access issues in the delivery system, including both the ease with which physician offices could be reached and the timeliness of appointment availability. In order to gather data on this, the call center did some “secret shopping” (gathering data on access and availability of appointments by calling physicians’ offices requesting an appointment) and revealed that there was a systems problem, particularly because Medicaid managed care has specific requirements regarding access. From 2002-2006 the call center expanded to provide centralized appointment scheduling services to seven medical group sites and will soon cover the whole medical group.

<sup>75</sup> Customer service liaisons are currently the highest paid clerical employees at Montefiore.

<sup>76</sup> Customer Service Department, “Guidelines for Liaison Level Relegation,” 2005.

While 1199/SEIU and Contact Center leadership collaborated to develop the values and promotional structure of the department, they also strove to improve the quality of work life for customer service liaisons through innovative programs. For example, they established two start and end times so that employees could balance the demands of work and home; introduced a “3 o’clock stretch” and other activities to keep employees physically active despite the sedentary nature of their work; and celebrated national customer service week during the month of October, for which the customer service liaisons raise funds throughout the year. “You feel like you are a part of something at the Contact Center,” was a phrase that was repeated by many customer service liaisons, stressing their contribution not only to building a collaborative work environment in their department but also to improving the productivity and quality of service of the department.<sup>77</sup>

“Once you empower people,  
their whole mindset  
changes.”

Customer Service Liaison, Contact  
Center. Interview on 8/26/11.

### **Impact of and on the Union**

The labor-management partnership at the Contact Center has had a positive impact on quality improvement, customer service, and access to the services offered at Montefiore. The Contact Center has rigorously documented the quality of its calls and the performance of its staff since its expansion in 2000. Here, joint labor-management work has fostered greater transparency, especially in areas that have been the focus of quality improvement efforts. From 2005 to 2010 the Contact Center was able to improve its overall call quality score—measured on a 100 point scale by an internal evaluation rubric—from 85 to 90.<sup>78</sup> For its total inbound calls the Contact Center has been working toward a goal of 5 percent abandoned calls, an average time to answer of 30 seconds, and 80 percent of calls answered within 30 seconds. For the past year and a half, the Contact Center has attained the 5 percent abandoned calls goal, with an average time to answer of 41-44 seconds and 72-73 percent of calls answered in 30 seconds. The Contact Center is also working to reduce costs per inbound call and costs per contact, which includes inbound calls, outbound calls, email, and in-person contact. The figures in these areas have increased in recent years after a period of decline in the early 2000s due to capital depreciation of the Contact Center’s infrastructural investments. Still, costs continue to be lower than those recorded at the beginning of the Contact Center’s expansion. In 2010 the cost per inbound call was \$8.57 compared to \$9.94 in 2002 and \$6.85 at its lowest point in 2006. Similarly the cost per contact in 2010 was \$4.06, \$7.62 in 2004, and \$5.02 in 2007.

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<sup>77</sup> Interview with Customer Service Liaison (anonymous) on 8/26/11.

<sup>78</sup> Unfortunately, no comparative data exists prior to 2000.

Another powerful quantitative indicator of the Contact Center's success is its staff turnover rate, which dropped from 14 percent in 2008 to 7 percent in 2009 and again to 3.9 percent in 2010. The active collaboration between Contact Center management and 1199/SEIU points to the main success factors in the Contact Center's impressive quality improvement work. According to Steve Kulovits, it is the partnership with 1199/SEIU that has allowed the Contact Center to advance the quality of its services.

1199/SEIU has been a strong presence since the formation of the Contact Center in early 2000. The union and its representatives have remained drivers for change, participating actively in the design of the career advancement ladder and engagement activities for employees. As the largest unionized department in CMO, the Contact Center and its 100 employees represented by 1199/SEIU set a powerful example for union involvement and labor-management relations at CMO

### **Current Challenges**

1. **Engaging new employees:** Because the Contact Center's collaborative culture, values, and career ladder have already been fully developed and are strongly in place, Contact Center leadership and 1199/SEIU now must consider how best to integrate a new customer service liaison hire into the department's unique environment.
2. **Extending partnership within CMO:** Although the relationship between labor and management at the Contact Center is strong and positive, similar relationships do not exist throughout CMO. Other areas within CMO may not have as strong a partnership as the Contact Center. Finding more effective processes to engage the input and expertise of all staff throughout CMO will be essential to improving labor-management relations across the organization and spreading the quality improvement outcomes that have already been attained by the staff of the Contact Center.

### **Conclusion**

Labor-management partnership activities at Montefiore's Contact Center have made a considerable impact not only on the ways in which labor and management work together but also on the Contact Center's overall work environment and processes. Because the Contact Center's leadership and 1199/SEIU have collaborated closely since the unionization of the Contact Center's workforce in 2000, the union and its members have played a large role in shaping staffing levels and departmental goals. Staff members feel that their voices are heard. The Contact Center's tradition of promoting from within fosters a culture of solidarity and understanding between labor and management. Finally, both staff and managers are encouraged to see themselves as innovators and leaders in the development of collaborative work processes and a customer service approach that serves both CMO, and Montefiore as a whole.

Activities at the Contact Center have proven successful in achieving positive environmental outcomes and, therefore, in providing a model that could be replicated elsewhere in CMO. The



export of the Contact Center's culture of collaboration could have a powerful impact on labor-management relations throughout CMO.

## CUMULATIVE OUTCOMES

The four labor-management partnerships profiled in this paper have influenced significant outcomes that benefit not only clinical processes but also the workplace environment and labor relations. The following section will highlight key outcomes from San Rafael, San Diego, Fletcher Allen, and the CMO, The Care Management Company.

**Clinical Processes:** At San Rafael, San Diego, Fletcher Allen, and Montefiore, making clinical processes more efficient, patient-centered, and cost-effective is a central goal of partnership work, and it is the area in which efforts have been the most successful. Initiatives across the four medical centers have led to outcomes such as:

- The number of referred home care patients who are seen within 24 hours increased from 44 percent in January 2010 to 83 percent in November 2010 (Home Health Care department, San Diego).
- The fall rate decreased from 3.07 falls per 1,000 patient days in 2010 to 2 falls per 1,000 patient days in January and February 2011 (Baird 3 Surgical Unit, Fletcher Allen).
- Laboratory staff achieved the benchmark of a 45-minute stroke alert test result (Clinical Laboratory Services department, San Rafael).

Through labor-management joint work, the four medical centers were able to devise creative and powerful solutions that took into account the input of the front-line staff members who are responsible for many of the details of patient care to achieve these and other strong clinical improvements.

**Work Environment:** The institution of a labor-management partnership at the four case study sites provided a much-needed venue for front-line staff and management to come together to tackle issues of quality improvement, safety, cost control, and work process redesign. Relevant trainings and an effective oversight process have contributed to the institutionalization of joint work, fostering workplaces in which front-line staff and managers feel comfortable discussing their perceptions of where and how processes can be improved on their units.

This collaborative environment has encouraged labor-management teams to find solutions to environmental problems and to improve the quality of work life throughout their respective healthcare systems. Notable outcomes include:

- There were zero reported workplace-related injuries in 2010 and two in the first five months of 2011 (Clinical Laboratory Services Department, San Rafael).
- Overhead pages were reduced from 450 per month to 422 pages per year (Operator Services Department, San Rafael).
- Multidisciplinary rounds were introduced department-wide (Inpatient psychiatry, Fletcher Allen).

**Labor Relations:** Labor-management partnerships have the potential to shift the paradigm in which labor and management interact from adversarial to collaborative. Although the four case study sites still experienced difficulty communicating and working effectively in partnership, all made significant improvements to the ways in which staff interact with each other and with management. Furthermore, labor-management partnerships have helped to create more stable workplaces that feature reduced turnover, reduced staff walkouts, and decreased arbitrations regarding changes in job descriptions.

**Cost Savings:** An effective labor-management partnership can have a considerable impact on the expenditures of a single unit and the bottom line of an entire healthcare organization. Specific cost-savings that resulted from joint work processes include the following:

- \$51,000 reduction in backfill costs (Operator Services, San Rafael).
- Reduced staff turnover rate from 14 percent in 2008 to 3.9 percent in 2010 (Montefiore's Contact Center).
- Reduced cost per communication contact from \$7.62 in 2004 to \$4.06 in 2010 (Montefiore's Contact Center,).
- Reduced nursing staff turnover and traveling nurse hires (Fletcher Allen).

## CUMULATIVE BEST PRACTICES AND SUCCESS FACTORS

While the success of a labor-management partnership approach depends to a certain degree on situational variables and personalities, the four case studies presented in this working paper reveal a concrete set of factors that contribute to the successful initiation and continuation of strong joint work.

1. **Proactive Union and Management Leadership:** Creating a joint labor-management process that benefits the union as well as patients requires strong and consistent union

and management leadership with clear and realistic goals. Union leaders must remain focused and develop an ongoing campaign to keep members engaged in order to sustain partnership. The case study of VFNHP provides a clear example of the ways in which proactive union leadership can be the catalyst for the development of a strong partnership process. Jennifer Henry, past president of VFNHP, was able to use collective bargaining creatively to win the support of her union's executive board and Fletcher Allen hospital administrators for the creation of MUPs. Strong management leaders are also needed to ensure that the spirit of partnership is adopted by hospital managers and administrators and that budgeting and scheduling decisions are made collaboratively.

2. **Clear Partnership Structure and Collective Bargaining Language:** A clear partnership structure is necessary to ensure that the union and its members have a direct role in decision-making, quality improvement and work process redesign projects. Collective bargaining language can help to clarify the goals of joint work while articulating the roles and responsibilities of those involved in partnership activities. Such language, although specific, must not be rigid and must reflect changes in the partnership process as it evolves. Furthermore, as front-line staff and management begin joint work activities, there needs to be appropriate just-in-time education of all staff members as to their role within the partnership. Staff members at Fletcher Allen and Kaiser Permanente note that many staff members are not fully aware of the purpose of the partnership and therefore may be resistant to participation in joint work. A clearly articulated partnership process and appropriate education can counteract this roadblock to success.
3. **Institutional Support for Partnership:** One of the reasons that the Kaiser Permanente LMP has been so successful at both the organizational and the unit level is attributable to the way partnership is presented as "the way business is run." Kaiser Permanente celebrates the success of its partnership activities and is constantly educating its employees about the value of partnership. The Coalition of Kaiser Permanente Unions is similarly supportive of joint work. Institutional support for partnership activities includes providing necessary education, training, access to information, and sufficient off-line time to dedicate to partnership initiatives for all involved in the joint work process. Institutional support for partnership from both management and labor union leaders generates enthusiasm for joint work. Such strong support gives visibility to the process, allowing staff to see that their efforts are appreciated and respected at the highest levels and connecting front-line staff to a shared vision for the institution.
4. **Communication and Accountability:** As all staff members do not always have direct ways to participate in partnership activities, one of the largest challenges faced at the four medical centers has been facilitating communication between those who actively participate in joint work and those who do not. Tools such as communication trees,

communication boards, e-mail, and huddles are essential to maintain a flow of information from core team members and unit staff and to facilitate the participation of all unit staff in partnership activities.

5. **Monitoring and Tracking Results:** Monitoring and tracking results has been a challenge for all of the health systems profiled in this paper. Continuous quality improvement involves the constant reassessing and readjusting of the initial solutions put into place. Only by keeping detailed records and analyses will labor-management partners be able to respond to problems that arise with solutions backed by data. Additionally, it is important to share the successes of joint work with peers, patients, varied stakeholders, external partners, and regulatory groups in order to illustrate the power of partnership—and the roadblocks to its success. A comprehensive method of tracking projects and their outcomes will facilitate easy sharing and communication.

## **NEW ROLES FOR LABOR UNION LEADERS AND MEMBERS**

Restructuring the United States healthcare system to be more cost-effective at a high level of quality will require innovative and diverse problem-solving initiatives. If front-line staff are to have a strong presence in redesign work, unions will need to find proactive ways to engage them. Clearly, union leaders and members will continue to focus on traditional union functions such as collective bargaining, grievance handling, advocacy, and political action while simultaneously facilitating quality improvement and joint work projects. Healthcare unions must be seen as partners with management if they are to remain a viable institution of value to their members, along with patients and the larger community.

For union leaders to become champions of joint work and quality improvement processes, they need to keep abreast of research and best practices in healthcare policy and partnership work. They must not simply wait for hospital administrators and management to initiate processes to improve patient care and control costs. Rank-and-file members also need access to critical information so that they are prepared to partner with management and other healthcare workers on unit-based and hospital-wide quality improvement projects. Finally, as is the case for the Coalition of Kaiser Permanente Unions, unions must work collaboratively in hospitals and clinic settings to strengthen and deepen the partnership process. Just as labor and management tend to believe that they work in different spheres, many union members have ended up relegated to silos. These boundaries between healthcare labor unions and between labor and management must be made more flexible and adaptive for partnerships to take hold and for quality improvement work to be successful.

The four case studies included in this report provide concrete examples and a general roadmap for healthcare unions to use to improve our healthcare delivery system. Nevertheless, continued

studies and exchanges between healthcare unions with assistance, when appropriate, from researchers and practitioners can help unions become leaders in improving patient care and controlling costs. If unions take the initiative to share and learn from each other, hospitals and communities will see their value, and members will understand the impact they can have on the way health care is delivered in this country.

## **TOWARD THE FUTURE OF LABOR-MANAGEMENT PARTNERSHIPS**

Unions have a central role to play in the current push to realign and develop new work systems to make our healthcare system integrated, affordable, and high-quality. As illustrated by the four case studies of this paper, labor-management partnerships provide an opportunity for union engagement in improvement efforts that can lead to sustained positive clinical, workplace environment, cost control, and labor relations outcomes. Of course, it is not a simple task to develop and keep in motion a partnership process. What these four case studies reveal is that the expertise of front-line staff and management can combine to achieve results that would have been difficult to achieve separately. Labor and management need to move beyond their traditional adversarial roles in order to redesign and restructure our healthcare system. This paper concludes with a concrete list of suggestions for labor and management leaders to consider when developing a joint work process. We hope these suggestions will provide a starting point for dialogue and implementation.

1. Cultivate strong and active labor union and management engagement.
2. Educate union members and leaders about the importance of improving the delivery of high-quality and affordable health care as a union goal, showing how it aligns with other union goals. In addition, educate union members and leaders about the value and purpose of labor-management partnership work—a process that is innovative as well as “optimizing”—and its centrality for achieving a variety of union goals.
3. Customize the partnership process. Clarify the structure of the partnership process and the roles and responsibilities of those involved. Select a specific approach or combination of approaches to focus the content and purview of partnership activities. Establish a labor-management steering committee to oversee and guide the partnership process and encourage staff participation.

4. Set clear goals that include union-building alongside specific clinical, workplace environment, and relational outcomes.
5. Focus on hospital-wide (strategic) and unit-based (operational) work.
6. Create contractual bargaining language to ensure the establishment of the areas of work mentioned above and to hold both labor and management accountable.
7. Negotiate specific resources to provide for internal and external consultants, coaches and educators as well as off-line time for front-line staff and steering committee work.
8. Redesign labor relations practices to establish early detection processes and a problem-solving rather than a punitive process for resolving worker issues.
9. Think big but remain accountable. No matter where you start, consider partnership work as a system process to respond to the complex structures, relationships, and value systems that exist in healthcare systems. Establish a clear and practical measurement and documentation process so that workers and managers get timely feedback about how they are doing.

## **A NOTE ON METHODOLOGY**

Research for this report was completed over an eleven month period from January to November 2011. We gathered information via group and individual phone and video conference interviews at Kaiser Permanente San Rafael and San Diego and Montefiore, group and individual on-site interviews at Fletcher Allen and Montefiore and review of internal documents and collective bargaining agreements supplied by our contacts at all four sites.

We interviewed a wide range of personnel at each site from front-line staff members to union representatives to managers. In total, we interviewed 85 individuals in 47 conference calls, video conference calls, and on-site focus groups and interviews at Fletcher Allen and Montefiore. Of the 85 people interviewed, 28 were Registered Nurses and other clinical staff, 16 were department managers or supervisors, 6 were internal and external partnership consultants, 11 were union representatives and executives, 17 were medical center or organizational executives and administrators, and 8 were clerical staff (with some overlap in roles).

When we entered the editing phase of compiling this report we contacted all those who had been instrumental in supplying us with access to information and/or had been quoted in the body of the manuscript. We incorporated feedback from these staff into the final draft of the report to

ensure overall accuracy. Their input and advice throughout this project has helped us get a candid picture of the activities of all four health systems.

## **FOR FURTHER INQUIRY**

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For more information regarding the medical centers, healthcare organizations, unions and partnerships cited in this manuscript, please visit the following websites:

Kaiser Permanente: [www.lmpartnership.org/home](http://www.lmpartnership.org/home)  
Fletcher Allen: [www.fletcherallen.org](http://www.fletcherallen.org) and [www.unitednurses.info/about](http://www.unitednurses.info/about)  
Montefiore Medical Center CMO: [www.montefiore.org/prof/managedcare/cmo](http://www.montefiore.org/prof/managedcare/cmo)

<p><b>Kaiser Permanente: San Rafael</b></p>	Labor-Management Partnership Structure	Labor-Management Partnership, Unit-Based Teams (all front-line staff and managers)
	Unions Involved in Partnership Work	-ESC Local 20 -UHW
	Goals	-improve labor-management relations -improve quality of care -improve workplace environment -improve cost-effectiveness
	Resources and Training	-labor-management partnership orientation -interest-based problem solving/consensus decision making -rapid improvement model (RIM+) -systems of safety -business literacy -managing in a partnering environment -performance improvement leadership -effective stakeholder training -labor and management team sponsors -online tracking software
	Outcomes	-improved communication -financial transparency -collaborative work environment -expanded role for union representatives -internal growth for unions -staff involvement in quality improvement projects -improved clinical outcomes
	Challenges and Learning	-lack of involvement of nurses impedes partnership process -engagement of all staff members for partnership activities is difficult to obtain -scheduling difficulties/time limitations for partnership work

	Labor-Management Partnership Structure	Labor-Management Partnership, Unit-Based Teams
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<b>Kaiser Permanente: San Diego</b>		(all front-line staff and managers)
	Unions Involved in Partnership Work	<ul style="list-style-type: none"> <li>-OPEIU Local 30</li> <li>-UNAC</li> <li>-AFSCME</li> <li>-UFCW</li> <li>-Unaffiliated Optometrists Local</li> </ul>
	Goals	<ul style="list-style-type: none"> <li>-improve labor-management relations</li> <li>-improve quality of care</li> <li>-improve workplace environment</li> <li>-improve cost-effectiveness</li> </ul>
	Resources and Training	<ul style="list-style-type: none"> <li>-labor-management partnership orientation</li> <li>-interest-based problem solving/consensus decision making</li> <li>-rapid improvement model (RIM+)</li> <li>-systems of safety</li> <li>-business literacy</li> <li>-managing in a partnering environment</li> <li>-performance improvement leadership</li> <li>-effective stakeholder training</li> <li>-labor and management team sponsors</li> <li>-online tracking software</li> </ul>
	Outcomes	<ul style="list-style-type: none"> <li>-improved communication</li> <li>-financial transparency</li> <li>-collaborative work environment</li> <li>-internal growth for unions</li> <li>-staff involvement in quality improvement projects</li> <li>-improved clinical outcomes</li> </ul>
	Challenges and Learning	<ul style="list-style-type: none"> <li>-focus on short-term crises rather than long-term quality improvement</li> <li>-limited number of union sponsors</li> <li>-impaired communication between team members and staff</li> </ul>

<b>Fletcher Allen</b>	Labor-Management Partnership Structure	Model Unit Process (nurses and nurse managers)
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<b>Health Care</b>	Unions Involved in Partnership Work	-VFNHP Local 5221
	Goals	-develop appropriate nursing staffing ratios -improve work processes and communication -improve patient care and infection control
	Resources and Training	-relationship-based care -clinical microsystems -Plan, Do, Study, Act methodology -external training consultant/facilitator
	Outcomes	-revised staffing ratios -financial transparency -increased communication -improved clinical outcomes
	Challenges and Learning	-lack of documentation -poor handoffs after the conclusion of MUPs impedes project follow-through

<b>Contact Center at the CMO, Montefiore's Care Management Company</b>	Labor-Management Partnership Structure	Labor-management partnership
	Unions Involved in Partnership Work	1199/SEIU
	Goals	-create good union jobs -create collaborative work environment -develop department mission and vision statement aligned with organizational goals in collaboration with department
	Resources and Training	-1199/SEIU Training and Upgrading fund to encourage staff obtainment of college degrees -Montefiore/ management sponsored training to support level moves -union sponsored communication and engagement training staff
	Outcomes	-open communication between management and staff -creation of 100 unionized customer service liaison positions -non-punitive promotional strategy -improved service quality and cost savings
	Challenges and Learning	-introducing new hires to existing collaborative culture -spreading similar partnership efforts elsewhere in the CMO

## Appendix A: Kaiser Permanente

### Collective Bargaining Language

Kaiser Permanente and Coalition of Kaiser Permanente Unions, AFL-CIO 2005 National Agreement (p.4-6)

#### b. Unit Based Teams

Engaging employees in the design and implementation of their work creates a healthy work environment and builds commitment to superior organizational performance. Successful engagement begins with appropriate structures and processes for Partnership interaction to take place. It requires the sponsorship, commitment and accountability of labor, management, and medical and dental group leadership to communicate to stakeholders that engagement in Partnership is not optional, but the way that Kaiser Permanente does business.

The 2005 Attendance, Performance-Based Pay, Service Quality, and Workforce Development BTGs recommended the establishment of teams based in work units as a core mechanism for advancing Partnership as the way business is conducted at Kaiser Permanente, and for improving organizational performance. A Unit Based Team includes all of the participants within the boundaries of the work unit, including supervisors, stewards, providers, and employees.

Members of a Unit Based Team will participate in:

- planning and designing work processes;
- setting goals and establishing metrics;
- reviewing and evaluating aggregate team performance;
- budgeting, staffing and scheduling decisions; and
- proactively identifying problems and resolving issues.

The teams will need information and support, including:

- open sharing of business information;
- timely performance data;
- department specific training;
- thorough understanding of how unions operate;
- meeting skills and facilitation; and
- release time and backfill.

Senior leadership of KFHP/H, medical and dental groups, and unions in each region will agree on a shared vision of the process for establishing teams, the methods for holding teams and leaders accountable, and the tools and resources necessary to support the teams.

Implementation of Unit Based Teams should be phased, beginning with Labor Management

Partnership readiness education and training of targeted work units, providing supervisors and stewards with the knowledge and tools to begin the team building work. It is expected that Unit Based Teams will be fully deployed as the operating model for Kaiser Permanente by 2010, in accordance with the timeline set forth in the 2005 Performance Improvement BTG report, page 7 (attached as Exhibit 1.B.1.b.).

Stewards and supervisors play a critical role in high performance partnership organizations. Where work is organized and performed by Unit Based Teams, the roles are substantially different from those of traditional work situations. References to supervisors in this Agreement refer to management representatives.

In Unit Based Teams, supervisors will continue to play a crucial role in providing leadership and support to front line workers. The role should evolve from directing the workforce to coaching, facilitating, supporting, representing management through interest-based procedures and ensuring that a more involved and engaged workforce is provided with the necessary systems, materials and resources. The role of stewards should evolve into one of work unit leadership, problem solving, participating in the organization and design of the work processes, and representing co-workers through interest-based procedures.

A description of the roles, as envisioned in the Pathways to Partnership, can be found in the Work Unit Level Sponsorship and Accountability section of the 2003-2005 Labor Management Partnership Implementation Plan and the 2004 Think Outside The Box Toolkit.

Kaiser Permanente and Coalition of Kaiser Permanente Unions, AFL-CIO 2005 National Agreement, Performance Improvement BTG Report (Exhibit 1.B.1.b)

By centering Partnership on DBTs, we also expect to eliminate parallel, duplicative structures in the organization. There will be fewer meetings, and more will be accomplished because all of the stakeholders are at the table from the beginning. This should help increase union capacity to partner, as well as reduce backfill issues.

We will know how well DBTs have performed by reviewing their performance on the metrics they have chosen, which will be aligned with the goals developed at the higher levels of the accountability structure in Recommendation 1. We would also expect to see improvements on People Pulse scores regarding influence over decisions, involvement in decisions, knowledge of department goals, and use of employees' good ideas.

Developing and implementing DBTs will incur costs, particularly for readiness training, described in more detail in our Recommendation 4, as well as release time and backfill.

#### Implementation Issues

A key enabler of this recommendation should be the growing sense of urgency, even crisis, among many of us that unless we make Partnership real to front-line employees, supervisors and stewards in the very near future, we will lose the opportunity forever. There is an equally motivating sense of crisis in the health care market – make significant performance improvement now, or lose market share. At the same time, we are well positioned to implement DBTs at this juncture: we have a shared vision of a high performing Partnership, we are committed to engaging employees, and we have the resources in place to support the development of DBTs.

We will have to overcome some barriers, including competing priorities and difficulty in measuring results across the program. We will have to work hard to overcome the project mentality that has taken hold of Partnership – it's a separate, parallel, off-line activity, rather than the way we do business every day. There may also be some concern over the idea that partnering in the business means shifting supervisor work to the DBT members.

#### Timeline

We envisioned a phased approach to implementation, with the first year focused on readiness training and education and developing a plan to enable employees, supervisors and stewards to operate differently. Again, some parts of the organization already do use DBTs; this plan will provide support for those that do not. The remaining years of the 2005 contract would be spent implementing DBTs, and measuring success based on the jointly developed metrics.

2006: Plan for and agree on a plan to prepare employees, supervisors and stewards to partner in Department Based Teams. Plan will cover needs for business education, training, facilitation, etc.

2007: Jointly-developed budget and regional performance objectives in place.

2008: Organization begins to see significant performance improvement attributable to DBTs.

2010: 100percent of the organization operating in DBTs.

#### b. Unit-Based Teams

Engaging employees in the design and implementation of their work creates a healthy work environment and builds commitment to superior organizational performance. Successful engagement begins with appropriate structures and processes for Partnership interaction to take place. It requires the sponsorship, commitment and accountability of labor, management and medical and dental group leadership to communicate to stakeholders that engagement in Partnership is not optional, but the way that Kaiser Permanente does business.

The 2005 Attendance, Performance Improvement, Performance-Based Pay, Service Quality and Workforce Development BTGs recommended the establishment of teams based in work units as a core mechanism for advancing Partnership as the way business is conducted at Kaiser Permanente, and for improving organizational performance. A Unit-Based Team includes all of the participants within the boundaries of the work unit, including supervisors, stewards, providers and employees.

Members of a Unit-Based Team will participate in:

- planning and designing work processes;
- setting goals and establishing metrics;
- reviewing and evaluating aggregate team performance;
- budgeting, staffing and scheduling decisions; and
- proactively identifying problems and resolving issues.

The teams will need information and support, including:

- open sharing of business information;
- timely performance data;
- department-specific training;
- thorough understanding of how unions operate;
- meeting skills and facilitation; and
- release time and backfill.

Senior leadership of KFHP/H, medical and dental groups and unions in each region will agree on a shared vision of the process for establishing teams, the methods for holding teams and leaders accountable, and the tools and resources necessary to support the teams. Unit-Based Team goals will be aligned with national, regional, facility and unit goals.

Implementation of Unit-Based Teams should be phased, beginning with Labor Management Partnership readiness education and training of targeted work units, providing supervisors and stewards with the knowledge and tools to begin the team-building work. It is expected that Unit-Based Teams are the operating model for Kaiser Permanente.

- The performance status of a Unit-Based Team is defined by the Path to Performance. (attached as Exhibit
- 1.B.1.b.(2))
- All Unit-Based Teams should be high-performing Unit-Based Teams. The parties agree that the following goals be established (high performance is defined as level 4 or level 5):
  - 2011: Double the number of high-performing UBTs that existed at the end of 2010.
  - 2012: Increase the number of high-performing UBTs by an additional 20 percent.
  - 2013: Increase the number of high-performing UBTs by an additional 20 percent.
- The 2010 LMP Subgroup of the CIC recommended, and the parties agree that:
- A uniform, national UBT rating system be established based on observable evidence and behavior.

The rating system is described in the Path to Performance. (attached as Exhibit 1.B.1.b.(2))

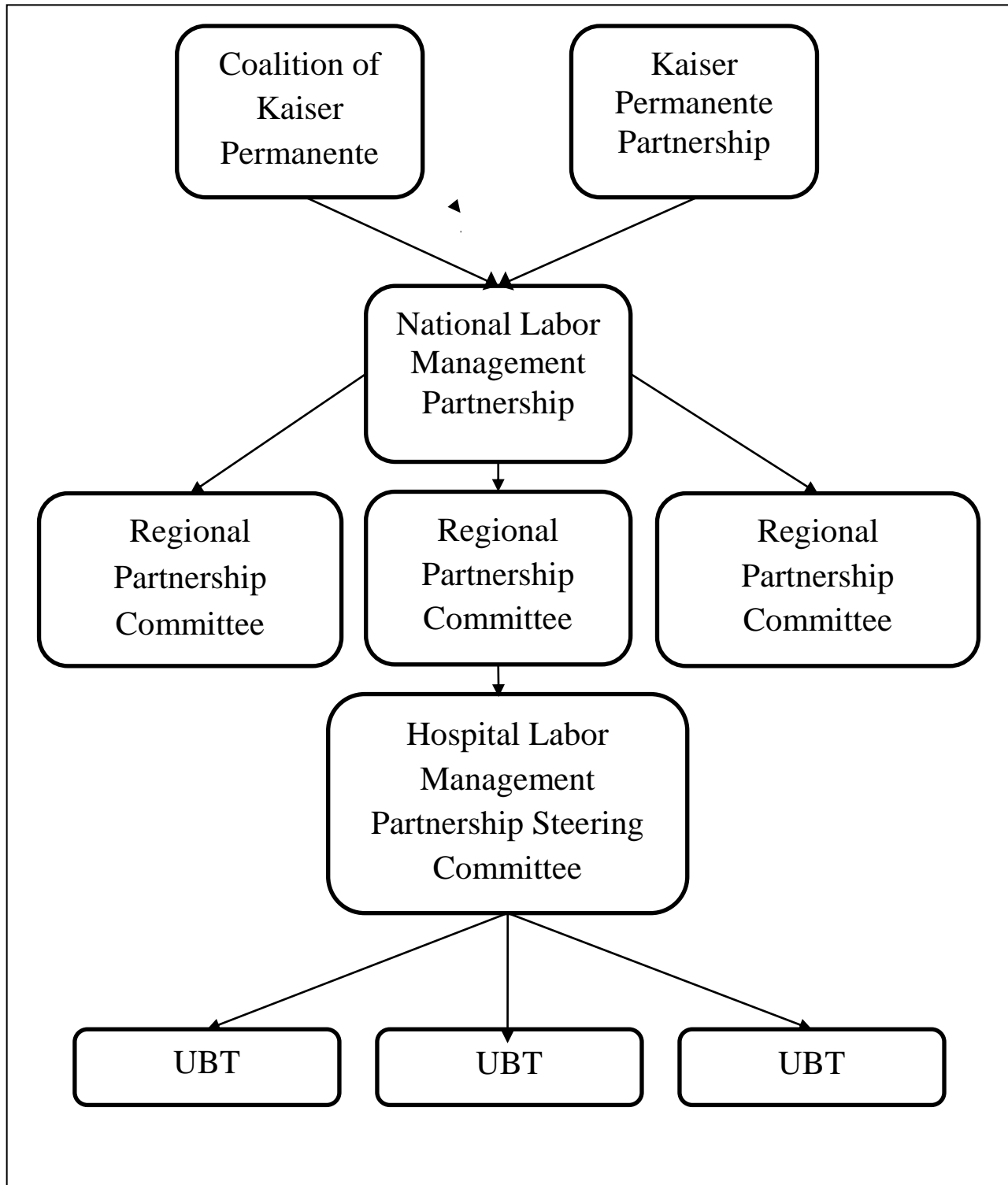
- The “National UBT Tracker” be refined to track high-performing UBTs.
- Mechanisms be developed to identify and support underachieving UBTs.
- High-performing UBTs be recognized and rewarded.

Stewards and supervisors play a critical role in high-performance partnership organizations. Where work is organized and performed by Unit-Based Teams, the roles are substantially different from those of traditional work situations. References to supervisors in this Agreement refer to management representatives. In Unit-Based Teams, supervisors will continue to play a crucial role in providing leadership and support to front-line workers. The role should evolve from directing the workforce to coaching, facilitating, supporting, representing management through interest-based procedures and ensuring that a more involved and engaged workforce is provided with the necessary systems, materials and resources. The role of stewards should evolve into one of work unit leadership, problem solving, participating in the organization and design of the work processes and representing co-workers through interest-based procedures.

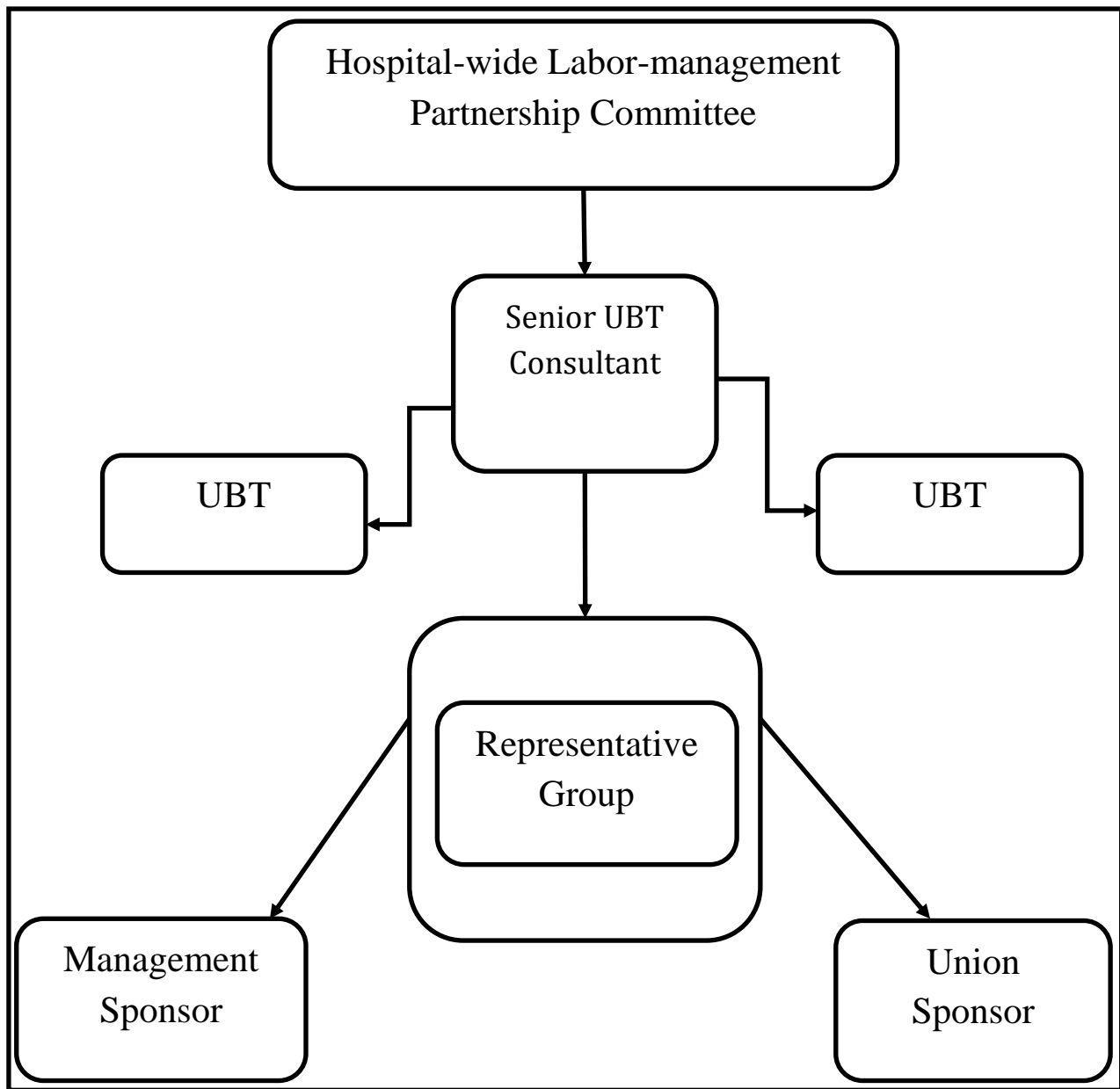
A description of the roles, as envisioned in the Pathways to Partnership, can be found in the Work Unit Level Sponsorship and Accountability section of the 2003–2005 Labor Management Partnership Implementation Plan and the 2004 Think Outside The Box Toolkit.



## National Labor-Management Partnership Structure at Kaiser Permanente



## Joint Labor-Management Partnership Structure at Kaiser Permanente Medical Centers



## Path to Performance Evaluation Rubric at Kaiser Permanente

### The Path to Performance:

#### Labor Management Partnership Team Development Pathway



#### Key Tip!

##### Ask yourself:

Where are your teams in the developmental process?

Who is developing and who isn't?

Why aren't they developing?

What do they need?

How can you and your co-sponsors support their evolution to the next level?

### Team Development

#### Stages of Unit-Based Team Development

Leaders and sponsors play an important role in the ongoing development of unit-based teams (UBTs). The more you understand about where your teams are in the developmental process, and what they need to move to the next level, the more effective you can be in supporting their forward momentum. The faster this process happens, the faster you will see results. Work with your co-sponsors to identify team status, strategize ways to help move them forward and develop a plan for long-term sustainability.

#### Guidelines for Using the Following Tool

1. Each quarter, give this tool to your teams and have them assess themselves. They must meet all the criteria in one level before they can move to the next level.
2. As the sponsor, part of your role is to track team status monthly. The P2P assessment tool gives you valuable information you can use to reward teams that are making progress and support those that are not moving forward at a desired rate.

Level 1	Level 2	Level 3	Level 4	Level 5
Pre-Team Climate	Foundational UBT	Transitional UBT	Operational UBT	High-Performing UBT
Unit is learning what a unit-based team is and how UBTs work.	Team is establishing structures and beginning to function as a UBT.	Team is demonstrating progress on engagement and making improvement.	Team has joint leadership, engagement of team members and improved performance.	Team is fully successful and collaborating to improve/sustain performance against targets.

## The Path to Performance:

### Labor Management Partnership Team Development Pathway

Clarifications are in blue

Dimension	Level 1 Pre-Team Climate	Level 2 Foundational UBT	Level 3 Transitional UBT	Level 4 Operational UBT	Level 5 High Performing UBT
<b>Sponsorship</b>	+Sponsors are identified and introduced to team.	+Sponsors trained. +Charter completed.	+ Sponsors regularly communicating with Co-leads. <a href="#">Minimum quarterly</a>	+ Sponsors visibly support teams. + Minimal outside support needed.	+ Sponsors holding teams accountable for performance and reporting results to senior leadership.
<b>Leadership</b>	+Team Co-leads are identified or process of identification is under way.	+Co-leads have developed a solid working relationship and are jointly planning the development of the team.	+ Co-leads are seen by team members as jointly leading the team.	+ Co-leads are held jointly accountable for performance by sponsors and executive leadership.	+ Team beginning to operate as a “self-managed team” with most day-to-day decisions made by team members.
<b>Training</b>	+Co-Lead training scheduled or completed.	+Team member training (e.g. UBT-O, RIM+) scheduled or completed. <a href="#">CDM, RIM or RIM+, UBT or LMPO and UBTM or UPR training.</a>	+ Advanced training (e.g. business literacy, coaching skills, metrics) scheduled or completed. <a href="#">(as needed)</a> <a href="#">+ Co-leads have received UBT Tracker training.</a>	+ Advanced training (e.g., Breakthrough Conversations, Facilitative Leadership, etc.). + Focus area-specific training (e.g. patient safety or improvement tools to address human error-related issues). <a href="#">As needed</a>	+Focus area-specific training. + Advanced performance improvement training (e.g., deeper data analysis, control charts, improvement methods via operational manager training). <a href="#">As needed</a>
<b>Team Process</b>	+Traditional; not much change evident. +Team meetings scheduled and/or first meeting completed.	+Staff meetings operating as UBT meetings (no parallel structure). <a href="#">Separate staff meetings and UBT meetings are OK. UBT-related content in Staff meetings should be presented jointly.</a> +Co-leads jointly planning and leading meetings.	+ Team meetings are outcome-based; team members are actively participating in team meetings and contributing to team progress and decision making. + Co-leads moving from direction to facilitation.	+ Co-leads jointly facilitate team meetings using outcome-focused agendas, effective meeting skills and strategies to engage all team members in discussion and decision making. + Team makes use of daily huddles to reflect on tests and changes made. + Team collects own data and reviews to see whether changes are helping improve performance.	+ Team beginning to move from joint-management to self-management with most day-to-day decisions made by team members. + Unit culture allows team to respond to changes quickly. + Team can move from first local project to next improvement project and can apply more robust changes. + Team measures progress using annotated run charts.
<b>Team Member Engagement</b>	+Minimal <a href="#">Member involvement in meetings is minimal.</a>	+Team members understand Partnership processes.	+ Team members understand key performance metrics. + At least half of team members can articulate what the team is improving and what their contribution is.	+ Unit performance data is discussed regularly. + Large majority of team members are able to articulate what the team is improving and their contribution.	+ Team members able to connect unit performance to broader strategic goals of company. + Full transparency of information. + Team is working on questions of staffing, scheduling, and financial improvement.
<b>Use of Tools</b>	+Not in use <a href="#">Team not using performance improvement tools.</a>	+Team members receive training on RIM+, etc.	+ Team is able to use RIM+ and has completed two testing cycles.	+ Team has completed three or more testing cycles, making more robust changes. (e.g., workflow improvement rather than training).	+ Team using advanced performance improvement training (e.g., operations manager training). + Team can move from initial project to next improvement effort, applying deeper data and improvement methods.
<b>Goals and Performance</b>	+Team does not have goals yet.	+Co-leads discuss and present data and unit goals to teams.	+ Team has set performance targets and targets are aligned with unit, department, and regional priorities.	+ Team has achieved at least one target on a key performance metric.	+ Team is achieving targets and sustaining performance on multiple measures.

## Rapid Improvement Model<sup>79</sup>



<sup>79</sup> Royal College of Psychiatrists Rapid Improvement Model, <http://www.rcpsych.ac.uk/quality/ctg-closingthegap/ctgprojectinformation.aspx>.

## **Appendix B: Fletcher Allen Health Care**

### **Collective Bargaining Agreement (2009-2011)**

#### **Schedules and Staffing**

##### **Article 20b - Model Unit Process**

The parties agree that the VFNHP and Hospital will develop a partnership so that the VFNHP will become integrated and involved in decisions related to the model of care, including the staffing model. Therefore, the parties agree that they will facilitate the Model Unit Process (MUP) in every unit/department or healthcare service in which there are bargaining unit members with the intent of creating a collaborative culture, reducing financial impact and building a systems-wide approach to quality improvement. The Hospital and the VFNHP will hire Bonnie Walker, Quality Consultant (or if Bonnie is not available, another consultant mutually acceptable to the parties) as a neutral facilitator to work with the Hospital and the VFNHP to refine the design and implementation of the MUP project, with costs of the consultant shared equally between the Hospital and VFNHP.

The following factors will be required in each MUP and the results of the MUP will be summarized in each final report:

- Unit profile
- Unit surveys, including a Core Process Survey, Staff Satisfaction Survey and a Clinical Microsystems Assessment Survey
- Unit-specific quality data, including unit-based improvement initiatives
- Staffing plan (grid)
- Staffing data, including the unit budget
- Financial impact of the proposal
- Metrics to be used to measure the effectiveness of the MUP proposal

Staffing plans developed under this Article 20B shall require approval by both the Chief Nursing Officer of the Hospital and President of each affected bargaining unit of the VFNHP.

The VFNHP and the Hospital recognize that the healthcare industry is in a state of constant change. This environment of continuous change requires that we provide ongoing training and skills to help our staff prepare for, participate in and accept change with a positive, collaborative approach. In addition, our staff members need to understand strategies for promoting a positive environment for change, as well as strategies for handling resistance to change. These skills will help build a strong foundation for our continuous quality improvement efforts in the future.

The Hospital and the VFNHP recognize that patients are grouped by their need for specialty nursing care. The Hospital and the VFNHP will, through a collaborative process, ensure that all units reach the appropriate level of standards. The VFNHP and the Hospital will determine, with the facilitator, which groups of units/departments and healthcare services will participate in the collaborative model together and the timeline for the process to complete. The timeline and plan will be developed within 6 months after the effective date of the agreement.

Each unit upon completion of the process will have its MUP plan as a side letter to the collective-bargaining agreement. The budgets for each unit will promptly be conformed to the standards and staffing developed in the MUP. If a unit experiences changes that necessitate changes in the MUP, the VFNHP and the Hospital agree to meet and confer about re-opening the process.

## **SETTLEMENT AGREEMENT**

This Settlement Agreement is made as of the 2nd day of March, 2006 by and between Fletcher Allen Health Care (the “Hospital”) and the Vermont Federation of Nurses and Health Professionals, UPV/AFT, AFL-CIO Local 5221 and Local 5221-L (the “Union”).

### Background

- A. The Union and the Hospital are parties to a Collective Bargaining Agreement, executed July 10, 2003 (the “Agreement”).
- B. The Union has filed a grievance (the “Grievance”) and initiated an arbitration proceeding (the “Arbitration”) asserting that the Hospital has not complied with the provisions of Article 20 of the Agreement, related to staffing. The Hospital has responded to the Grievance by asserting that it is in compliance with Article 20 of the Agreement. There have been several days of hearings related to the Arbitration, and the hearings are scheduled to resume on March 9, 2006.
- C. The parties have engaged in very productive discussions related to the Arbitration and the provisions of Article 20 and now desire to settle the Arbitration in accordance terms this Agreement.

Now, therefore, it is agreed as follows:

1. Withdrawal of Grievance. The Union will promptly withdraw with prejudice the Grievance and will not assert any other new grievance related to Article 20 of the Agreement that arose prior to the date of this Settlement Agreement. The parties will promptly notify the arbitrator assigned to the Arbitration that the matter has been fully settled and may be dismissed with prejudice.

2. No Admissions. Neither the execution of this Settlement Agreement nor the withdrawal of the Grievance or the dismissal of the Arbitration shall be deemed to constitute an admission by either party with respect to any of the positions asserted by the other party in the Arbitration or otherwise.
3. Amendment of Article 20. In consideration of the withdrawal of the Grievance and the dismissal of the Arbitration, the parties agree that Article 20 of the Agreement in its current form ("Existing Article 20") shall be amended in its entirety to provide as set forth in Exhibit A ("New Article 20"), together with Exhibit 20A to be effective immediately upon approval and ratification by both parties. This will not preclude collective bargaining regarding an "Understaffing Wage Differential" or regarding the section of Exhibit A entitled "Section 20A".
4. Interim Interpretation and Administration of Article 20. Following the ratification of New Article 20, the Hospital's staffing budgets and plans for each unit shall continue to be consistent with the staffing ratios that were developed for that unit under the Existing Article 20, and as currently applied on the unit, until a different staffing plan is developed and approved for that unit under the New Article 20. During such interim period, both parties reserve their rights with respect to the interpretation and administration of Existing Article 20 as asserted in this Arbitration, but neither party shall assert any grievance or claim with respect to same issues or the same Grievance that have been asserted in this Arbitration; provided, however, the Union reserves the right to grieve based on a violation of the first sentence of this paragraph.
5. Reopener. If the Union is not satisfied with this Agreement after one (1) year from the date of execution, the Union can provide sixty (60) days' written notice of its desire to reopen Article 20 of the collective-bargaining agreement, and the parties shall meet and negotiate in good faith. Any amendment to Article 20 that results from such negotiation shall be subject to ratification by the Union. After bargaining to a good-faith impasse, either party may exercise the right to strike or lockout to convince the other party to accept its proposal on Article 20 and nothing in the collective-bargaining agreement shall prohibit such action.



## **SIDE LETTER REGARDING**

### **Joint Staffing/Model Unit Process**

The parties agree that the following documents shall be used to describe and establish the Joint Staffing/Model Unit process referred to in Article 20:

#### **Joint Staffing /Model Unit Project Charter**

1. Purpose of the Unit Committee
2. Goal (completion date)
3. Membership
  - All shifts and job classifications in the department- up to 2 nurses from each shift, the Nurse Educator and the Care Coordinator(s).
  - A VFNHP Executive Board member chosen by the VFNHP Executive Board
  - All nurses will be paid for their time in committee.
  - Department Manager, Nursing Director and one other management representative to be chosen by the management.
  - Co-chairs will be selected from union and management
  - A neutral facilitator
4. Process

Follow the Joint Staffing/Model Unit plan template to structure unit recommendations.
5. Responsibilities of the Committee
  - Develop a unit mission statement
  - Develop a model of care that will deliver high quality care
  - Ensure that job responsibilities and duties are defined for all jobs in the unit and conform to VT State Board requirements regarding scope of practice and all relevant national nursing specialty standards.
  - Define the skills and competencies for all staff recommended in plan
  - Ensure that all affected staff has an opportunity for input and are regularly communicated with concerning progress.
  - Identify systems issues that need to be addressed to support the model unit goal
  - Identify resource and training needs

- Develop staffing plans with the patient being the core of planning and provide supportive data, rationale etc. for recommendations. (Utilize support from staffing committee).
- Design a community where team members share the gain and pain to meet our goal of delivering safe, high quality, competent, patient centered care.
- Establish measures of success for the plans developed.
- Present unit recommendations to Staffing Committee, Labor Management Committee, Magnet Committee and Professional Nursing Council groups upon completion.

6. Authority

Upon completion of the mutually agreed to staffing plan, the plan will be presented to the Labor Management Committee for final signature approval by the CNO and the Presidents of each of the bargaining units affected in the plan.

### **Joint Staffing Model Unit Plan Template**

1. Unit Mission and Scope of Service

Describe:

- Mission of the unit
- Target patient group including nature of services provided on the unit
- Volume data for the unit including discharge, transfer and admission activity
- Physical size, geography, equipment, technology, and clinical characteristics of unit.

2. Best Practice Review

Utilize staffing committee and unit Nurse Educator to gather information on best practices for this clinical area.

3. Model of Care

Describe:

- The optimum patient experience
- Build flow chart of patient experience and critical clinical interventions
- Review patient and staff satisfaction data
- Review NDNQI data as well as other outcome data
- List assumptions about how changes will improve patient care and job satisfaction

4. Roles and Responsibilities

- List the job categories necessary for delivering the model of care
- Describe the duties and responsibilities of each of the roles
- List competencies, training and experience requirements for each job category

- Identify the assumptions about how the roles and responsibilities will improve patient care, management and job satisfaction

#### 5. Staffing Model

- Review unit/departmental budget including overtime utilization and use of traveler nurses
- Agree on a formula to justify staffing levels that includes census and acuity
- Provide criteria for why the model chosen is appropriate
- Develop a detailed daily schedule, including break schedule and other needed work rules, for each of the above roles.
- Plan for replacement needs
- Plan for staff education needs, research, participation in governance, etc.
- Plan for fluctuations in staffing needs with changes in volume and acuity
- Review staff illness and injury data for the unit
- Identify the number of people needed in each job classification to fill each shift.

#### 6. System Wide Issues Affecting the Unit

- Staff mix
- Technology (bed board, transport system, etc.)
- Review the availability of support resources
- Plan the necessary staff levels of support services

#### 7. Define Metric/Measures of Success for the Unit

- Current measures and targets
- Proposed measure and targets

#### 8. Meeting Minutes and Support Documentation

#### 9. Conclusions and Recommendations

- Identify resources needed that require budget allocation
- Identify systems issues that will need to be addressed to ensure successful implementation.
- Indicate who should address the system issues.

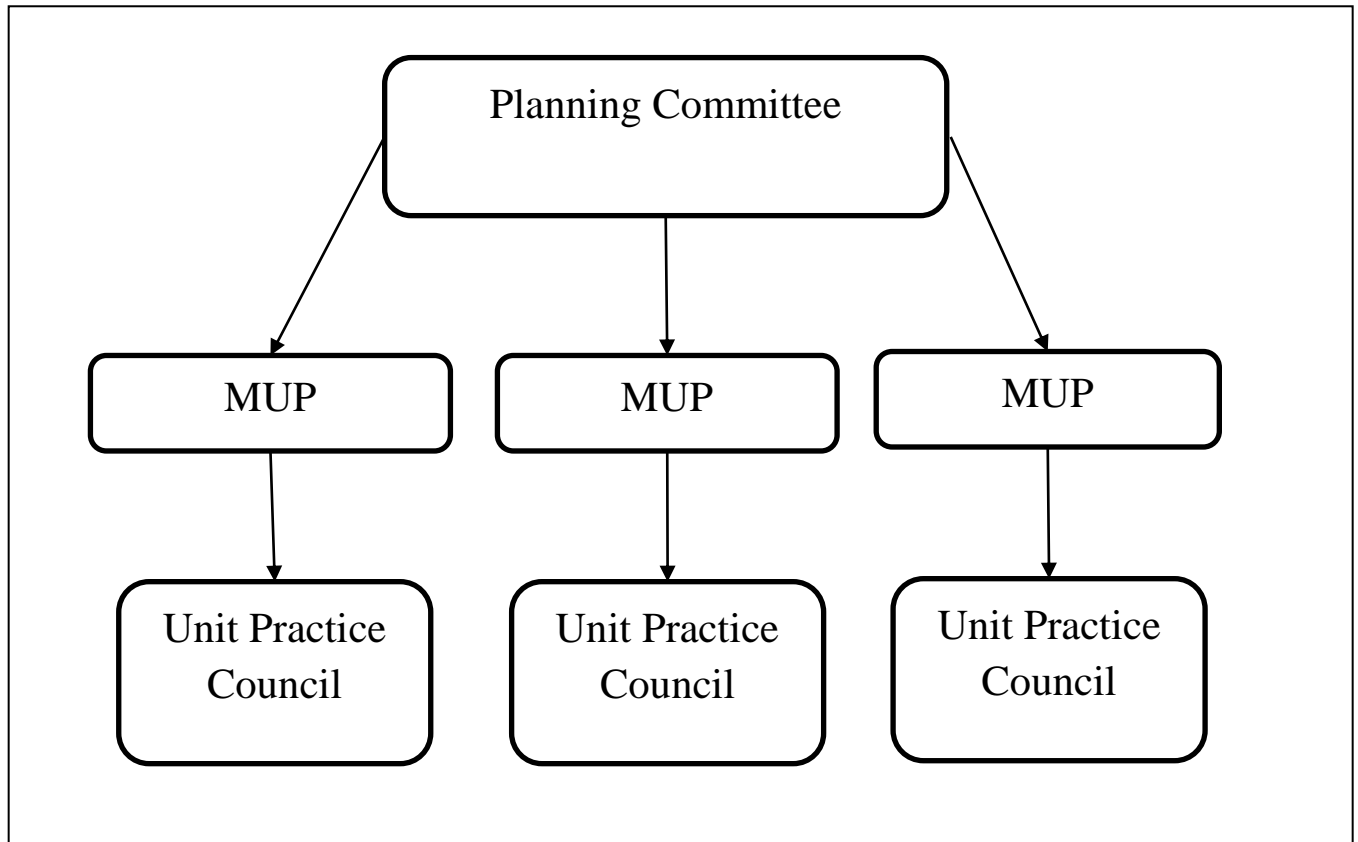
#### 10. Implementation

Identify:

- Implementation tasks
- Implementation dates
- Responsibility for accomplishing the tasks

- List the measures of success that will be used to evaluate the Unit.

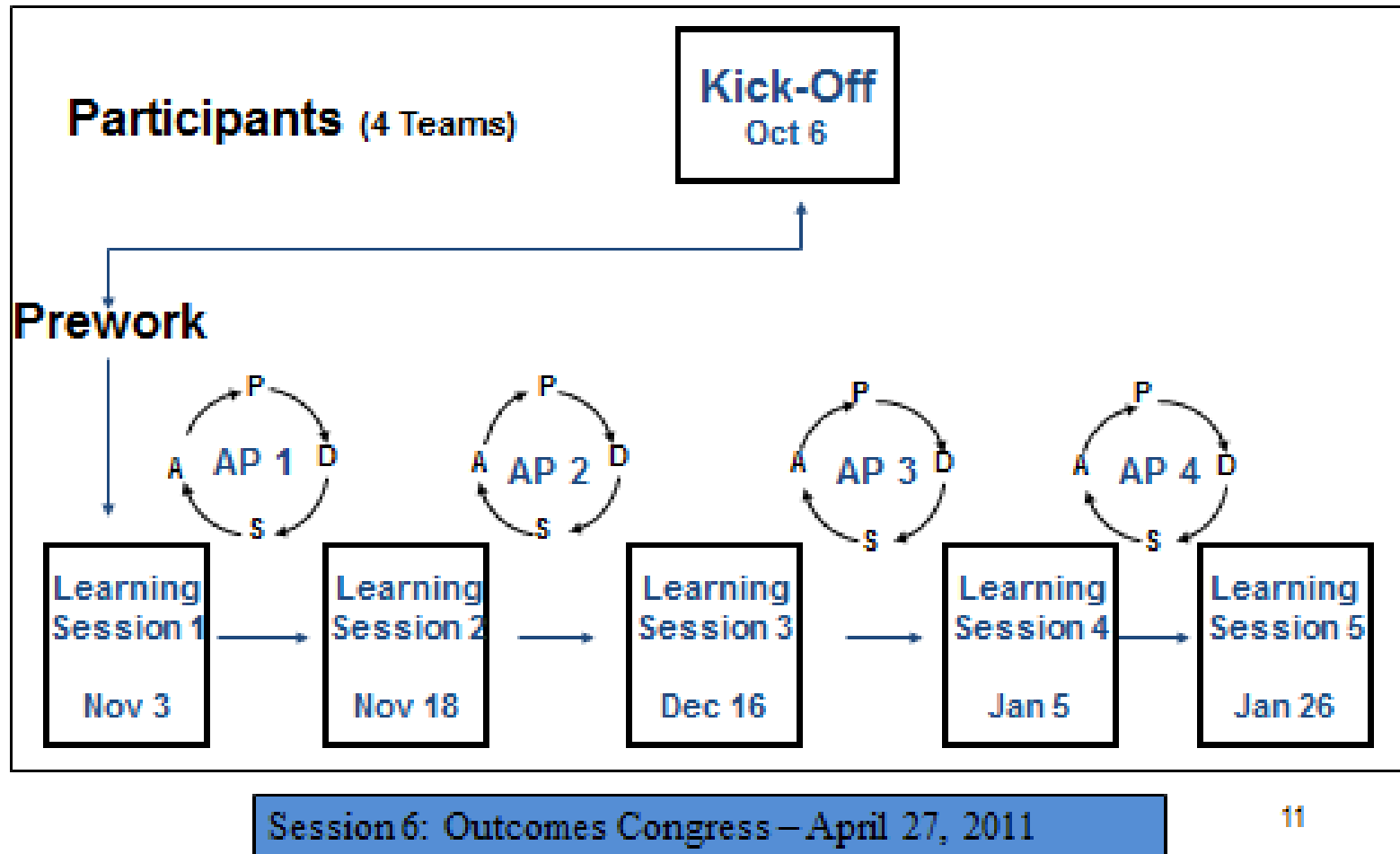
### **Model Unit Process Structure at Fletcher Allen Health Care**



### MUPs Core Process Survey

Core Process	#	Examples	Scale				
			Works Well	Small Problem	Totally Broken	Don't Know	Not Applicable to this unit
<b>SYSTEM-WIDE PROCESSES</b>							
<b>Admission</b>	1	Admission Process					
	2	Admission Process: Off-service					
	3	From Emergency Room					
	4	From Direct Admits					
	5	From Cath Lab					
	6	From OR					
	7	From Other:					
	8	Referral Process					
<b>Transfer</b>	9	Transfer Process					
<b>(circle To OR From)</b>	10	To/From ICU (which one?)					
	11	To/From Inpatient					
	12	To/From Cardiology					
	13	To/From PACU or OR					
	14	To/From PPR					
	15	From Fanny Allen to MCHV					
<b>Discharge</b>	16	Discharge process					
<b>Communication</b>	17	Communicate with Patients					

# Our Model Unit Process Timeline



## **Appendix C: Montefiore Medical Center**

### **Timeline of CMO, The Care Management Company Development**

**1996:** Formation of the IPA, CMO, The Care Management Company and MBCIPA; CMO signs contracts with Aetna, Oxford, NYLCare, US Healthcare, Blue Cross/Blue Shield, 1199 Professional Services Cap, United Healthcare, and PHS bringing in a total of 52,000 lives

**1998:** CMO executive offices moved to Yonkers

**1999:** CMO signs agreement with HIP to bring in 5,000 capitated lives

**2000:** CMO negotiates with HIP to take on their entire Bronx and Westchester population, bringing in approximately 126,000 lives; CMO terminates contracts with plans whose data analysis and information systems are poor and retains contracts with HIP, Healthnet, Oxford, Empire Medicare, and United Healthcare; expansion of the Contact Center

**January 2000:** Installation of new care management system and upgraded claims system

**2002:** Development of chronic disease management programs beginning with heart failure; use of telemonitoring devices; beginning of collaboration with the Montefiore Medical Group

**2002-2003:** Strengthening of data analysis and increased use of hospital data to determine services provided to CMO members

**2003-2005:** Development of the Medical House Calls program initially designed to find patients who were not connected to health services but ultimately provides primary care home visits to homebound patients

**2004:** CMS demonstration project; development of diabetes care management program

**2005:** Development of patient education services

**2008:** Development of respiratory care management program

**2009:** Creation of the Office of Community Health to engage Bronx community to improve health outcomes

**2010:** Development of Patient Centered Medical Homes at Montefiore Medical Group Sites