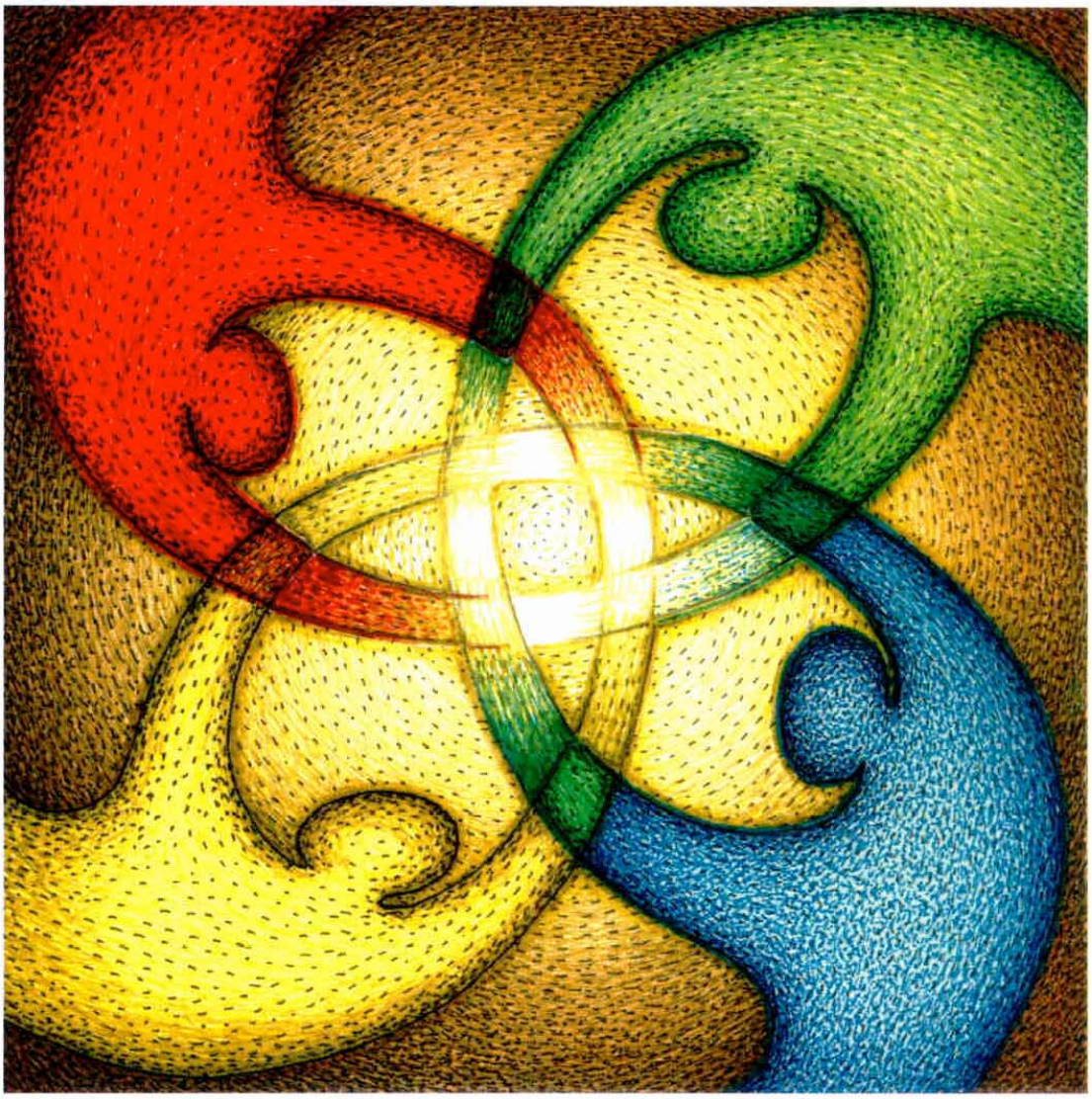
The Kaiser Permanente Labor Management Partnership, 2002-2004

By

Paul S. Adler
Adrienne Eaton
Paul Gerhart
Robert McKersie
Phyllis Segal

The Kaiser Permanente Labor Management Partnership: 2002–2004



Thomas Kochan, MIT Institute for Work & Employment Research
Robert McKersie, MIT Institute for Work & Employment Research
Adrienne Eaton, Rutgers University School of Management & Labor Relations
Paul Adler, University of Southern California Marshall School of Business
Phyllis Segal, MIT Institute for Work & Employment Research
Paul Gerhart, Case Western Reserve University Weatherhead School of Business

The Kaiser Permanente Labor Management Partnership: 2002-2004*

Thomas Kochan, Robert McKersie, Phyllis Segal

Paul Gerhart

Adrienne Eaton

Paul Adler

*This research is funded by the Kaiser Permanente Labor Management Partnership Trust Fund. It continues the analysis presented in our first report: Susan Eaton, Thomas Kochan, and Robert McKersie, The Kaiser Permanente Labor Management Partnership: The First Five Years, MIT Institute for Work and Employment Research, 2003. Available at http://mitsloan.mit.edu/iwer. The views expressed here are solely those of the authors.

Table of Contents

I. Introduction, Background, and Prior Work

This report analyzes the evolution of the Labor Management Partnership at Kaiser Permanente (KP) from 2002 to the present time and identifies a set of critical issues and challenges the parties will face in moving forward. We build on and extend our prior report that reviewed the history of the Partnership from the time of its formation in 1997 to 2002.

Leaders of the Labor Management Partnership requested that we study the Partnership to (1) provide an independent review and public documentation of their experiences as the Partnership evolves, and (2) identify challenges and opportunities facing the parties at this stage of the Partnership's history. To do so over the period of June 2002 to December 2004, we have interviewed over 200 management and labor representatives, physicians, nurses, clinicians, other professionals, and facilitators involved in the Partnership. In this phase of our research we focused on specific projects and facilities that Partnership leaders suggested would provide a good window on the Partnership and the issues, challenges, and dynamics experienced in implementing these projects in different KP regions and locations. These projects are listed in Figure 1. We make no claim to have studied a representative sample of the range of activities underway under the Partnership umbrella.

Figure 1
Projects Studied

Region	Location	Project Focus
Northwest	Sunnyside Medical Center	Joint staffing project
Northern California	Fresno Medical Center	Overall partnership with focus on the opening of two medical office buildings, revenue capture, and service enhancement
	Napa/Solano	Overall partnership with focus on the cost reduction initiative in the clinics
Ohio	Region-wide	Overall partnership with focus on the Ambulatory Redesign Initiative
Southern California	Region-wide	Overall partnership with focus on three psychiatric units
	Baldwin Park	Department-based teams
National		Joint Marketing Initiative

Interviewees were assured that their views and comments would be held anonymous and that we would only attribute statements to them with their permission. In addition we collected as much data as possible to understand the regional and service area contexts in which these projects are situated. We have also reviewed the large volume of documents the parties have collected to record their work and experience to date and the results of the People Pulse surveys (KP's internal employee survey). We have attended numerous meetings of the Coalition of Kaiser Permanente Unions (CKPU) and of Partnership leaders and staff at the national, regional, service area, and facility levels. Each of the members of our research team was encouraged to draw his or her own independent conclusions in their case studies. The consistency of the findings that emerged across thee studies gives us confidence in our conclusions.

What follows here is first a summary of our findings and conclusions to date. We then discuss factors that influence the success/failure of Partnership initiatives by drawing on a model of labor management partnership and change that mixes theory from labor management relations and the behavioral sciences with concepts, terms, and tools used by KP Partnership leaders and staff. The final section of the report offers thoughts on moving forward to the next stage of the Partnership. Full reports of our regional and project studies are available on our website and will be published separately.

II. Summary

Figure 2 presents the goals of the LMP Partnership as originally outlined in 1997 and supplemented (with goal number 7) in 2002. We use these goals as reference points in examining how the Partnership is currently evolving.

Figure 2

Kaiser Permanente National Labor-Management Partnership Goals

- Improve the quality of health care for Kaiser Permanente members and the communities we serve.
- Assist Kaiser Permanente in achieving and maintaining market leading competitive performance.
- Make Kaiser Permanente a better place to work.
- Expand Kaiser Permanente's membership in current and new markets, including designation as a provider of choice for all labor organizations in the areas we serve.
- Provide Kaiser Permanente employees with the maximum possible employment and income security within Kaiser Permanente and/or the health care field.
- Involve employees and their unions in decisions.
- Consult on public policy issues and jointly advocate when possible and appropriate.

The Initial Five Years

In our report on its first five years we noted that creation of the Partnership is in itself an historic achievement since it represents the most ambitious Partnership in place in the U.S. at the moment and one of the most comprehensive and complex in the history of U.S. labor relations. The signal achievement over this initial time period was the successful use of interest based bargaining principles and tools to negotiate a system-wide five year collective bargaining agreement. Other achievements included use of Partnership principles and processes to open Southern California's Baldwin Park Medical Center in record time and restructuring and dramatically improving the performance of the Optical Laboratory in Northern California. Beyond these highly visible substantive accomplishments, we noted that the parties had put in place a comprehensive Partnership governance structure and process and trained hundreds of union and management leaders in Partnership principles and skills, agreed on specific performance targets, and implemented over 50 different Partnership projects in different work sites.

We concluded that report by noting the parties faced a clear set of challenges in moving forward:

> "Indeed, the Partnership is at a critical juncture. There is a clear sense of urgency in the minds of both labor and management leaders that calls for integrating Partnership into operations, and broadening the base of progress. If the parties do so, the Partnership will advance to gain broader support and achieve more significant results. Failure to do so, however, could result in a slow atrophy of the progress to date and/or a return to the more traditional adversarial relationships of the past."

2002-2004 Highlights

Three years later the Partnership continues to stand out as a beacon in American labor relations. The parties have not only sustained but expanded, deepened, and strengthened their Partnership, particularly among national level labor, management, and physician leaders.

Sustaining this high level of support is not something that can be taken for granted in any partnership. Indeed, "pivotal events" tend to arise from time to time that test the parties' ability to work through difficult problems that could potentially pose a threat to the partnership's survival. In 2002, for example, following a series of management leadership changes, top KP executives, physicians, and leaders of the CKPU came together for a frank and pivotal "reexamination of the future envisioned under the Labor Management Partnership." Out of these meetings came a reaffirmation of the original Partnership vision and an implementation plan for moving

forward.[1]

More specifically, some of the major achievements in the past three years include:

1. Joint efforts to address a number of serious financial crises and budget problems that occurred as a result of unanticipated membership declines in several regions.

2. Expansion of the number and range of Partnership projects in different regions. A comprehensive count is not available but by the end of 2003 at least 145 projects had been identified. Many more have been started in the past year.

3. Significant increase in the number of employees involved in Partnership activities. The most recent data report that 39 percent of employees are involved, an increase from 22 percent in 2000.

4. Gradual but significant improvement in employee attitudes as measured in the People Pulse survey. Employees who are involved in Partnership activities (compared to those not involved) are significantly more satisfied with KP as a place to work and to receive health care, with the amount and accuracy of information they receive, their ability to influence decisions affecting their work and with their managers' willingness to use their ideas for improving operations.

5. Significant reductions in grievance rates in most regions. Step 3 grievance rates among partner unions went from 15 in 1998 to 7.1 in 2003 program-wide.

6. Growth in the number of union members covered by the Partnership from approximately 58,000 in 1998 to 81,000 in 2004. These numbers include newly hired and newly organized workers as well as the addition of some existing local unions that joined the Partnership.

7. Deepening of support for the Partnership among senior leaders of the Kaiser Foundation Health Plan and Kaiser Foundation Hospitals (KFHP/H), the Permanente Medical Group, and the Coalition of Kaiser Permanente Unions. This is particularly noteworthy given the leadership transitions and new appointments in senior positions that occurred in recent years in the KFHP/H

[1] "Labor Management Partnership Vision: Reaffirmation & Understandings," August 21 and November 6, 2002.

since these types of leadership transitions have often proved to be difficult for other partnerships.

8. Expansion and deepening of the infrastructure of the partnership, i.e., the number of union representatives and management personnel who possess the knowledge, training and abilities needed to use partnership principles and processes to solve specific problems and/or to carry out their daily activities. In some cases leaders have made hard decisions to move management and labor leaders who are not able or willing to support partnership efforts out of positions of responsibility. These examples signal a strong support for the Partnership and serve to reinforce its centrality and value to KP and its employees and unions.

9. Broadening of the issues addressed through the Partnership that in the past were normally reserved for unilateral management action. Examples include a joint marketing initiative, consultation in the process of appointing executives to senior positions, and participation by representatives of the Coalition at meetings of the Kaiser Permanente Planning Group (KPPG).

At the same time, the parties have been less successful in meeting some of the Partnership's initial goals.

1. Most of the cost savings achieved to date have come from one-time budget cuts involving reductions in hours or staffing (without resort to layoffs). As noted above, these came largely in response to specific crises provoked by projected or actual membership declines or other unanticipated events. The parties have been less successful in translating their achievements in these one-time problem solving efforts into ongoing day to day management and work processes focused on improving the delivery of health care and the quality and satisfaction of work. Thus, only limited progress has been made on the stated objective of integrating Partnership principles and processes into operating management. As a result, in most settings, the Partnership continues to be viewed as more of a labor relations program and initiative than as a vehicle for delivering high quality health care services.

2. The parties have not yet seen significant improvements in several national priorities, including safety, attendance, and market growth. They have, however, made some more limited progress on these problems in specific locations. And some promising developments have begun to emerge. A new Comprehensive Safety Management Program has been launched that appears to be designed and structured in ways consistent with national benchmarks for improving workplace health and safety. Similarly,

after a slow start, a number of joint marketing initiatives have increased the membership during open enrollment periods, retained existing members at risk of switching health care providers, and gained new accounts.

3. Despite repeated efforts, the parties have yet to put in place a system for tracking the performance outcomes of Partnership activities that is capable of measuring the return on investment, or linking the LMP to improvement in the quality of health care, or improvements in the working experiences of employees.

4. The intensive time and resources and numbers of people required to implement the Partnership have strained union and management and physician staffs. The capacity to engage simultaneously in Partnership activities and carry out the operational responsibilities of these individuals continues to be a major concern in some regions and facilities.

5. Support for the Partnership remains variable across regions and within middle levels of management and union organizations. Since we find that strong management and union leader commitment and accountability are necessary conditions for Partnership projects to be successful, this continues to limit the Partnership from reaching its full potential.

6. Little horizontal diffusion or learning has taken place from one project to another or across regions. While extensive efforts are underway to communicate project experiences in innovative ways via newsletters and the Partnership website, we observed little evidence of parties seeking out lessons to be learned from other sites or evidence that a learning culture has yet taken hold across or within regions.

7. The opposition of the California Nurses Association (CNA) has kept some nurses from engaging in joint efforts. Efforts, for example, to reduce worker compensation costs in hospitals have been limited by the lack of participation of nursing staff. In other cases, CNA members participate, but as a consequence, the activity is not labeled "Partnership", thus diluting the "brand."

The parties now face three upcoming "pivotal events": the negotiation of another national agreement, the transition of leadership of the Coalition of Kaiser Permanente Unions (CKPU) from Peter diCicco to his successor, and the tensions within the union coalition that will inevitably spill-over from debates at the national level of the labor movement over the future role, structure, and membership of the AFL-CIO.

As the parties address these specific challenges, they will need to again address the deeper strategic question of whether the Partnership is to be largely a labor relations activity that runs in parallel to day to day operations or an integral part the way KP delivers health care services. By moving systematically in this latter direction, KP could not only continue to serve as a model for labor-management relations, but also as a model for how to improve the quality of health care delivery in America.

Based on our observations of the LMP in action to date and on what we have learned from partnership and change efforts in other organizations, we believe moving in this direction will require:

1. Complementing the top-down, project-focused initiatives (some refer to this as a cascading strategy) with more workplace-based performance improvement activities that involve employees, supervisors, physicians, and managers in ways consistent with generic partnership principles but may have less of the formal LMP structures, processes, and leadership control.

2. Measuring the results of improvement efforts against the key health care quality and other performance metrics of the operations involved.

3. Diffusing the lessons learned to comparable units by building personal networks through which peers draw on each other's experiences.

We will discuss these strategies for moving forward in more detail in the final section of this report.

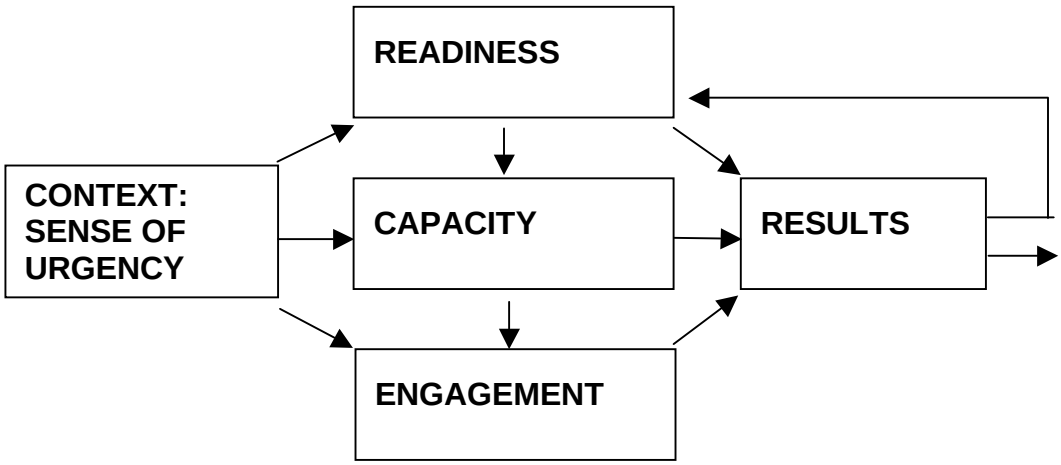
III. Framework Analyzing Partnership Projects

Figure 3 summarizes the framework we use to analyze Partnership activities and to structure the body of this report. It is based on well established theories of organizational change from the behavioral sciences and labor management relations[2] and uses the language and strategies Kaiser Permanente leaders draw on in implementing the Partnership. We will start by reviewing the context in which Partnership activities are situated, focusing primarily on the degree of urgency or crisis that motivates the project. Then we will analyze the structures and processes used to design and implement projects by drawing on the Partnership terms of readiness, capacity, and engagement. Finally we will draw

[2] See for example, Kurt Lewin, "Frontiers in Group Dynamics," Human Relations, Vol. 1, 1947, pp. 5-41; Thomas A. Kochan and Lee Dyer, "A Model of Organizational Change in the Context of Union-Management Relations," Journal Applied Behavioral Science, Vol. 12, 1976, pp. 59-78; John Kotter, "Leading Change: Why Transformation Efforts Fail," Harvard Business Review, March-April, 1995; Richard E. Walton, Joel Cutcher-Gershenfeld, and Robert B. McKersie, Strategic Negotiations: A Theory of Change in Labor-Management Relations, Boston: Harvard Business School Press, 1994.

on the best data available to report the results of the activity, both in terms of specific substantive results and their effects on on-going relationships, learning, and diffusion of partnership behaviors and principles. In using this model we will give special focus to "pivotal events" or challenges parties inevitably encounter in partnerships like this and discuss how they have been addressed, and their effects on the Partnership.

Figure 3: Heuristic model of LMP



IV. Key Findings

We will now use these categories and concepts to analyze and compare cases we have studied in different regions and worksites. Again we caution that these examples should be viewed only as illustrations of partnership dynamics, not as a representative sample of all partnership projects that are underway. Our purpose here is to use our cases to illustrate how these different elements in the model contribute to success or failure of Partnership initiatives.

Context: Financial Crisis as a Sense of Urgency

Most models of organizational change predict that a sense of urgency helps to motivate parties to initiate a change project. In the first phase of the Partnership, the sense of urgency came from the recognized need to reverse the downward spiral of adversarial relationships and conflict that the parties were in. In this second phase, various financial crises provided this sense of urgency. The Partnership seeks to get away from depending on a crisis or sense of urgency to motivate leaders to initiate action; however, our data suggest that the most successful projects continue to be ones driven by a shared sense of urgency or crisis. Several cost reduction initiatives illustrate this clearly.

As **Southern California** management began budget planning for 2004 in summer 2003, projections were for considerable membership losses and big budget shortfalls across the region. Southern California was anticipating a gap of perhaps $200 million relative to a budget of some $480 million. Healthplan and Hospital Program leadership felt forced to consider drastic steps to reduce labor costs. Some ideas on the drawing board such as margin relief would require renegotiation of terms of the collective bargaining and Partnership agreements; others such as reducing sick days, delaying wage increases, or layoffs, would require labor concessions.

When management met with labor and these ideas were put on the table, the labor representatives immediately decided that they would not countenance labor contract concessions. After considerable discussion among regional and national labor and management leaders, an agreement was reached that they would try to address their problems through cost structure improvements developed in partnership mode. Nationally, a joint committee was established to oversee such efforts across KP.

In fall, key labor leaders were brought into the Southern California planning discussion. The initial contacts were difficult because the labor leaders had heard of the initial concession plans. The parties persisted however, and undertook an intense round of trust-building and brainstorming. A small, top-level LMP team worked daily for over two weeks to identify savings for the 2004 budget. This group included regional executives and regional and national labor leaders, but no local operations managers, and no local labor representatives.

Through the intense work of this regional task force, trust was established, and savings of over $90 million were identified.

The Southern California example is a good illustration of what we refer to as a "pivotal event" in the life of a labor-management partnership, i.e., a crisis or problem that arises that could, if not addressed successfully, threaten the future or risk destroying the partnership but, if resolved successfully, tends to reinforce, deepen, and broaden support for it. In this example, if management in Southern California would have insisted on acting on its own to address the cost crisis and in doing so taken actions that would have produced layoffs or benefit cuts, the Partnership would have been put at risk. Instead, by facing the crisis together, the parties demonstrated the power of the Partnership.

As we will see, pivotal events like this one (albeit perhaps not as large in magnitude) have occurred and will undoubtedly continue to arise from time to time in this Partnership just as they do in all employment relationships.

Another example of successful focused effort on cost reduction was observed in the **Napa/Solano** service area in Northern California where operations had been running over budget for several years.

Napa/Solano experienced a "wake up call" when contrary to expectations enrollment dropped. Because enrollment had been flat or declining, and the service area had budgeted for an increase in enrollment, the organization found itself running a substantial deficit, and pressure mounted to correct the problem rather quickly. In 2002, the clinics had exceeded their budget by $10 million, and in 2003—at the pace realized early in the year—the deficit would amount to $15 million. As of April 2003, the deficit had already increased by an additional $3.5 million. The rule of thumb followed by the planners was that a drop in 1,000 members meant a loss of one million dollars in income. Therefore, the projected decline in enrollment during 2003, of almost 5,000 members, meant that if nothing changed they would be exceeding their budget by an additional $5 million. As a result, the decision was made to launch a special project, and to view it as a stand-alone activity, benefiting from the labor-management Partnership but not integrated with the governance of the Partnership at Napa/Solano.

The plan agreed to by the partners for reducing costs on the clinic side of the Napa/Solano service area set a target of $10 million by the end of the second year. Three months into the program it became clear to the steering committee that the suggestions coming forward from the departmental committees were insufficient and a new approach was needed. The parties recognized that they needed to shift from a fostering strategy (that had urged the departmental committees to be imaginative) to a forcing strategy (that would be more directive and bottom line oriented). So the steering committee decided to focus on savings that could be controlled from the top of the organization. Specifically, it was decided to freeze all hiring and to capture attrition as it developed. In order to deal with imbalances a swat team consisting of the chief steward, top administrators and the physician in charge met every morning at 6:30 to reallocate workers across the departments. As a result of the actions at the top of the system they were able to close the gap and meet the $10 million target for cost reduction.

For the first five years of the Partnership, most managers in the **Ohio** region assumed, as one put it, that partnership was "just another short-lived initiative from California" that would soon blow over.

The year 2002 was the turning point. Managerial job postings were changed to include a comment about working in a "positive labor-management climate" and working with the Partnership. More importantly, by mid 2002, it became apparent that there would be significant restructuring and downsizing needed to match the precipitous decline in membership over the preceding few years – from a peak of over 200,000 to about 145,000.

Plans began to be made for restructuring and in late 2002 they were disclosed to local union leaders at a regular Partnership meeting. The immediate reaction was dismay. It was readily apparent that planning had been going on for some time and that labor had not been involved. One union leader commented: "Looks like you got a plan already – why would that be?"

When the question quoted above from the union was raised, regional managers acknowledged that they had made a mistake in not bringing the restructuring issue to the Partnership group earlier. The real meaning of Partnership quickly became apparent to all the parties. They began to see the Partnership as a valuable tool for confronting the financial crisis and necessary restructuring.

Management, physician and labor leaders set a target of achieving $24 million in cost reductions by 2006. They decided to focus on redesigning the work of their ambulatory units. The Ambulatory Redesign Group (ARG) identified over 140 ideas ranging from small savings to very ambitious reorganization of departments. The package of proposals was forwarded to the top executives and health plan officials in Ohio and to national LMP leaders. Several months went by and no guidance had been received by the departments. Subsequently, the list was reviewed and pared down to a more manageable number of initiatives, and departments were given the go ahead to implement these changes.

But little progress occurred. Many of the ideas proposed by the labor-management team proved to be impossible to implement. So in early 2004 the leaders decided to regroup and to adopt a much more systematic method for getting results that involved holding regular offsite meetings with a facilitator who helped labor and management representatives plan and implement changes - with targets and timetables explicitly formulated and accepted. The participants were more careful this time to discuss proposed changes with people in the units affected to test their feasibility and to involve a broader range of people in the process. They labeled this the "ARG II" process.

This process proved to be effective. By the concluding sessions in October 2004, realistic projects had been identified that would save an estimated $21.2 million across 16 departments. The parties were well on their way to achieving the target of $24 million by 2006.

In our parlance, the financial crisis proved to be a key pivotal event for the Partnership in Ohio. Significant downsizing that would have likely ended prospects for the Partnership was avoided and instead the Partnership was finally launched. As will be noted later in the report, it also had the beneficial effect of engaging physicians in the Partnership in a concrete and meaningful way, to the point that in Ohio the parties refer to the Partnership as the "LMPP": The Labor Management Physician Partnership.

The poor performance on a number of metrics put the **Fresno** Medical facility we studied in a perilous position and fueled some if not much of local union representatives' enthusiasm for partnering. This sense of urgency provided the energy needed for the parties to work together on revenue capture and cost reduction projects. Stewards in this facility repeatedly spoke to their passion and pride in helping to keep the doors open and workers in their jobs. A steward involved in the revenue capture project spoke to the culture change required to

collect co-pays at the point of service: "It's so hard when someone's sick to go in there and ask for money. It's hard. I said, 'Get over it here. We're drowning. We could shut down if we don't collect our revenue.'" Another steward involved in the cost reduction effort spoke to the importance of and motivation for this work:

> "For [the Director of Hospital Operations] to be able to say we were in the black [last year], you know, because of all these little projects multiplied by how many times across the facility, really made me feel like we're making a difference. We're helping keep the doors open, we're helping keeping us employed. That's how I see it."

Initiating and Sustaining Partnership in the Absence of Crisis

Note that the most success in responding to crisis has involved cost reduction. This is understandable since a cost crisis is relatively concrete and presents immediate and clear consequences if not addressed. However, crisis driven change tends to be, as we observed, episodic, not continuous in nature. At some point either the crisis recedes, as appeared to be the case in **Southern California**, or if remains acute, the parties get frustrated by their inability to make progress. In either event crises eventually lose their motivating force unless reinforced by more internally driven forces. In **Napa/Solano**, for example, the parties' have not been able to translate their successful cost reduction experience into a strategy for on-going work redesign or continuous improvement efforts across the Service Area.

In some cases, however, the parties have been able to sustain commitment to the Partnership in the absence of a crisis. Several of these cases are ones in which the parties were initially motivated by crisis conditions and have been successful in adapting Partnership principles and processes into standard, day to day operating procedures after the crisis has abated.

The **Optical Laboratory in Northern California** appears to be such a case. A internal memo to KP senior management described the performance history of the laboratory:

> "We all know the story of the Northern California Optical Lab so well, we may discount it. It is important to remember that this early success continues to pay off. The profit margin for optical sales was 22% in 2003 – sustaining the results of the previous 5 years even though we lost membership. While revenue has grown, staffing has remained flat, resulting in a 45% increase in revenue per optometrist between 1997 and 2003."

Similarly, support for the Partnership has been sustained at **Baldwin Park** long after its successful and highly acclaimed involvement in designing and opening the Baldwin Park Hospital. In this case, however, sustaining the Partnership required the parties to recover after the "co-management" model used when the hospital opened was widely perceived to have failed. Looking back at this period,

Assistant Medical Center Administrator Sheryl Sack recounts "We put people from labor into a role expecting them to manage without the skills…No thought about what was needed to develop their skills." UNAC/UHCP's Jacqueline Asfall describes how "a lot of animosity developed among the rank-and-file members. They believed people taking these roles no longer supported labor when they wanted to become managers."

As flyers began to circulate in the hospital urging labor to pull out, the Partnership was, in the words of one participant, "coming to a roaring halt."

To the parties' credit, they used the problem solving process to regroup. Baldwin Park's LMP Steering Committee was reorganized to include unit managers and labor representatives, and an investment was made in foundation building, especially training. By late 2002, an initiative was underway to develop "Department Based Teams," which decentralize partnership by moving it to the Medical Center's front lines.

The contrast between two projects in **Southern California** illustrates the importance of moving beyond crisis. A **Pediatrics Immunization Project** was a showcase of highly effective partnership activity, one of the few that involved high levels of physician involvement. But the momentum for continued improvement dissipated when the information reporting system changed and no longer called out specifically the immunization rates for this specific age group.

In contrast, the **Sunset Psychiatric** unit was a showcase for very effective partnership, here around improving patient access times. This project too was motivated by a crisis that galvanized action. In this case, however, the project, once completed, mutated into a governance team that could address the implementation issues. This governance team has maintained its vitality in particular because it was confronted with a new important challenge that is not just a transient crisis -- how to improve utilization (i.e. productivity) while not impairing access, patient satisfaction, or employee satisfaction. This is a classic "service delivery model" problem, and as such, it is complicated and debates have been tense. But this is a problem whose durable rather than transient nature prompts an ongoing rather than short-lived partnership dialogue.

The Pediatric Department in Napa/Solano is a case where the parties were able to both initiate and sustain Partnership initiatives in the absence of a visible crisis. When the Partnership took hold in the late 1990s, it was clear that Pediatrics would be one of the first departments targeted to receive training and to have a committee formed. As one of the stewards said:

> "We had lots of communication problems in the department, low morale, a lot of inner turmoil, and there was no quick fix, no way to resolve these issues."

The Joint Labor-Management Partnership Committee, formed in 2001, consisted of ten individuals: six support staff, the physician in charge, the department manager and assistant manager, and one other member of management. Independent facilitation was provided; however, as the stewards commented, "We went through three different facilitators."

Early in the work of the Committee, a mission statement was crafted, and the members of the Committee received training in interest-based problem solving and consensus decision-making. The Committee met twice a month for four hours. Several subcommittees were established, including Workflow, Environmental, and Safety. Each subcommittee was co-chaired by a member of the departmental Labor-Management Committee, as well as a manager or a physician. The committees were fleshed out with individuals from the department who volunteered. A department manager described how the support and involvement of the Physician in Charge energized this effort:

> "One of the things we decided in the LMP committee was that we could figure out a way to become one- on- one, one doctor to one medical assistant, which helped morale from the beginning because that's something everybody had wanted for a long time anyway, but we were always told that it couldn't happen. But once our Physician in Charge got on board to figure out a way to make this happen, the workflow committee went forth to do this."

In interviews with members of the department, the issue of trust was frequently identified as critical. For example a steward noted:

> "You know the trust issue is important because we've always been a "them-and-us" type thing. And so becoming a "we" took a little bit to adjust to. So it's been a slow process. But as we move forward with the LMP, we've been able to say that we can make a difference. So I think our members can see a difference in it, that it's a positive thing."

The Partnership has made it possible for rank-and-file members to approach management. Another steward noted:

> "With the Partnership, we feel more comfortable going to management and talking to them about different things that are going on in the department. I represent the support staff, and none of them have a problem coming to me and complaining! I feel totally comfortable going to the key managers and talking to them about our issues, and we work through whatever the issues are."

These examples illustrate a key point:

Sustaining Partnership-initiated changes in the absence of an immediate crisis requires a focus on the way work is carried out on the front lines on a daily basis, i.e., around the way KP delivers health care services, and needs broad-based involvement of managers, physicians, union leaders, and employees. All these parties have to see working in partnership as a means for doing their work in a better and more satisfying way.

The key factors affecting the success of on-going efforts will be discussed below as we focus on the internal structure and process dimensions in the change model outlined in Figure 3.

Readiness

Partnership leaders and staff use the term "Readiness" to indicate the extent to which the parties are willing to engage each other in a Partnership mode. The key to this is the history and current state of labor-management relations in the worksite, the commitment and vision of key sponsors, and the extent to which managers and union leaders are held accountable for results.

State of Labor Management Relations

Given the decentralized nature of KP operations and structure, it is not surprising that the climate and history of union, health care and hospital management, and physician relationships vary considerably across locations and regions. This variation affects the success of the Partnership and its rate of diffusion. Not surprisingly, good relations provide a positive platform to take up Partnership projects. In contrast, settings with highly adversarial or arms-length labor-management-physician histories have found it difficult, and in some cases, impossible to make the Partnership work. In these settings, the root causes of their adversarial tensions need to be addressed first before moving on to engage in other Partnership initiatives.

Partnership leaders have recognized this point. In 2004 a "Readiness" program was initiated by identifying a small number of settings where adversarial tensions have persisted and assigning facilitators to work with the parties in those settings. The Los Angeles Medical Center illustrates just how difficult this task can be.

A history of hostile labor-management relations at the **Los Angeles Medical Center** had generated a large backlog of problems. Some union members began placing "stickers" protesting workplace problems in different areas of the worksite. The mounting tensions and the desire to turn the labor-management relationship around led to an agreement to have two experienced facilitators work with labor and management leaders in an Issue Resolution Process. The facilitators convened several meetings in the summer and early fall, 2004. Each party brought a number of issues to the process. Labor representatives were

concerned about lack of management support and involvement in some of the department level teams and councils that were created and about management unilateral decision-making in other units. Management wanted the union leadership to demonstrate a good faith commitment to Partnership as opposed to traditional labor relations by publicly repudiating and halting the "sticker campaign." The union leaders indicated they did not support the use of this tactic but indicated that they could not control those using it. They countered with the view that they first needed evidence of changes in management that union rank-and-file members could see as representing management's goodwill and commitment to changing what they saw as managers' bad behavior. The facilitators ultimately concluded that the unit was not ready to engage in the type of problem-solving required for the Interest Resolution Process to go forward.

By taking the step of withdrawing their services, the facilitators sent a clear message to both union and management leaders in the facility: Unless you are willing and able to engage in a good faith effort to address the root causes of the adversarial tensions in your relationship we are all wasting time and resources in trying to jumpstart Partnership initiatives. In this instance, sending this message activated a response. Regional management and labor leaders intervened and began working with local leaders to address the causes of the tensions in this facility. While not yet "ready" for new Partnership initiatives, they appear to be moving in this direction. This proves once again that "sponsorship" is a critical component of readiness.

Undoubtedly there are other highly adversarial settings within KP that are similarly not suited to Partnership initiatives at this point in time. The Readiness initiative is one way Partnership leaders and facilitators have in place to work with parties in these situations. However, as in the example cited above, interventions by facilitators alone are not likely to be successful. The ones that have been successful all had personal involvement and reinforcement from higher level managers and union leaders who make it clear they will be holding local leaders accountable for changing their relationships.

Shared Vision

It is common for organizational change models to emphasize the importance of having a shared vision among organizational leaders. The initial vision for the Partnership was very ambitious, particularly in terms of the scope and the depth of joint decision-making, consultation, and the amount of information sharing the parties expected to achieve. The parties also expected partnership principles would be integrated into the operations and processes used to carry out KP's mission of delivering health care services.

Clearly having a shared vision of the broad principles and goals of the Partnership provides a good starting point for any Partnership interaction,

however, often how these broad principles can be fitted to specific problems and settings only emerges as the parties begin to grapple with specific problems. Disconnects in the parties' understanding can cause frustration and strain the Partnership. In the membership marketing initiative, for example, the tension between two different approaches to partnering for marketing is described by both labor and management. Robert Hochberger, Southern California Regional LMP co-chair and CKPU National Coordinator stated, for example:

> We've told management that we're not interested in the piecemeal assistance they are looking for from us. What marketing folks have done, even where there is a joint committee, is work an account, try to either get in for the first time or increase penetration, and do most, if not all, of the planning and most of the initial contacts without letting us know. And then they come in at the last second to tell us they are having problems and tell us who should call whom and what we should say, and by when…
>
> In [one region] we did a school district intervention, followed their script, and contacted folks they said we should. At the end of the day it produced nothing. We said we need to take a strategic approach to this, be partners in marketing, not be told who/what/when after you find a problem. We want to sit down… and think strategically both short term and long term. Look at all the aspects of marketing. How do we increase penetration, gain access, leverage our relationships, how do we maintain a good relationship with the labor union. This means we sit down together, choose targets jointly, think about the big picture, be involved in rate setting… Also how do we connect, from a regional perspective, as a PR machine, manage the relationship between KP and the labor movement…Think about this from a broad umbrella, strategically, broad based. Let us in on the rate-setting process so we have a better understanding of that. Kaiser will struggle with this.

A Regional Sales Executive also described this struggle:

> My sense is that although everybody is politically correct [about involving our union people on account strategy], there is reluctance to have unions at the table when we are setting budgets and rates.

As the Partnership moves forward with membership marketing, a key challenge is adapting the vision of partnership to this arena, and resolving how Kaiser's sales and marketing team and the union partners can work together most effectively to expand KP's market share.

As the examples below illustrate, the vision for the Partnership also varies considerably across regions and facilities.

In the **Northwest Region**, labor and management leaders at the regional level have developed a shared vision of Partnership as an operating strategy. In

practice, at the regional level, this means the inclusion of labor in developing strategy and in sharing accountability for the implementation of decisions. The regional President, Cynthia Finter, described two primary ways in which the region's approach differed from others.

> "[First], my declaration that my labor partner is an equal. That there should be shared decision-making, strategy, and accountability. A formal declaration. And then getting the Medical Group and Dental Group leaders to share this. . . [Second, we've] made three years' investment in learning through budget-setting, strategy setting at the 'senior table' and pushing that two levels down." At the same time, "[t]he vision is not co-management. That's not my vision, not Kathy's Schmidt's vision [her labor partner], it's not the Medical Group leader's vision. But we have to approach [co-management] or maybe even engage in it to learn what the limits are."

Further, this vision has been backed up with clear direction for managers: "You will partner."

We can see this vision in practice through another pivotal event, this time at the Northwest Region's only hospital, **Sunnyside Medical Center**. In the fall of 2003 multiple unions in the facility conducted a solidarity action in the hospital focused on problems in the EVS department. Regional management felt the reaction violated an informal "no surprises" rule. Workers were beginning to lose patience with the lack of progress with partnership – most had seen little change from the LMP. Around the same time, there was an incident in the Emergency Department where a nurse, in the view of at least some labor representatives, was unfairly disciplined. Relationships could easily have deteriorated further at this point. But instead, Joint Staffing teams were brought together for a "Celebration Day", the Sunnyside CEO was assigned her full-time labor partner, the EVS manager first went out on leave and then left the organization and a few months later the CEO was replaced and the region began restructuring in ways that facilitated partnership.

Ohio has taken another approach, one that, as noted earlier, explicitly includes physicians as partners in their "Labor Management Physician Partnership (LMPP). Physician involvement in the Partnership in Ohio came about because the physician staff realized that significant restructuring was about to occur that would affect the delivery of healthcare – perhaps even what specialties in health care might be delivered or discontinued in the future. They knew their interests were going to be at stake. For this reason they wanted to be involved.

The Emergency Department headed by Dr. Peter King is a case in point. According to King, neither the doctors nor the Emergency Department had anything to do with the Partnership until the ARG process began. He felt it was politically and practically necessary to become part of the ARG process (and hence the Partnership). He was concerned that with the ARG process looking to

cut costs, the department would become a target and might even be eliminated altogether.

More generally, it was clear that with downsizing coming, the physicians knew that Health Plan Management might not always see matters from their perspective. Thus, rather than letting management represent their interests they concluded that they should have their own seat at the table.

Being directly involved has served as a catalyst for changing physicians' perceptions of labor leaders and their role in the delivery of health care. Dr. Walid Sidani, Vice President and Associate Medical Director for Medical Affairs, commented:

> "Now, as we are experiencing the partnership we are seeing from the physician perspective that it is really nice having [the union representatives] here, because we didn't know how they think or what ideas they have. They really know something, but we didn't know that before.
>
> It takes longer and sometimes it doesn't achieve what you want right away because now there are different opinions coming and you are going to have to look at it, but what we are seeing is that if you really apply that [Partnership principles], in the long-run you will end up with more sustainable results. The old way you may have quick results and then you look at it 3 months down the line and say, 'What happened, nobody's doing it.' Nobody bought into it. That's the kind of experience we are seeing."

Sidani also indicated that it often takes this type of direct exposure of physicians to the Partnership to overcome negative perceptions of employee and union participation derived from prior bad experiences.

In **Fresno**, the parties have also crafted their own approach to the Partnership. There the parties created labor and management partners starting with the leadership in the facility working down to most mid-level management and stewards. They do not see this as a full "co-management" model, but one aimed at signaling to all in the facility that partnership principles and behaviors are built directly into these leadership structures and management and labor representative roles and that stewards and workers should be involved in improving patient care and other organizational objectives in a day-to-day way.

Baldwin Park illustrates how the parties adapted their vision for the Partnership from operating with co-management to a more decentralized approach with department based teams that work on Medical Center priorities and projects created by the teams. The successful experience opening the Hospital built confidence in the strategy of engaging labor in collaborative problem solving and decision making in areas where they had not previously had

any say. After the initial co-management in some of the outpatient units was perceived to have "failed," the shared vision of engaging labor led to creating a department based team model throughout the Medical Center.

These examples show that there is not one uniform shared vision for the Partnership across the KP and union coalition. Different regions and within regions different facilities are developing their own local views on how to best shape the Partnership to meet their specific needs. How much variation is necessary or desirable continues to be a matter of some debate. What is critical, however, is that management, labor, and physician leaders in a given region or facility develop and share a common vision for how to adapt and fit the basic principles of the Partnership to their settings.

Accountability

One of the biggest impediments mentioned in our interviews was whether or not managers were being held accountable for following Partnership principles and behaviors. Our data suggest that this is another essential predictor of success or failure of project efforts.

Considerable progress in holding management accountable can be seen, particularly at the national levels of management and in the **Northern California** and **Northwest** regions.

This was clearly a key factor contributing to the success of partnership at **Fresno**. Mid-level managers at Fresno made clear that they are under pressure to partner and that some managers who found they couldn't adapt have left voluntarily. Stewards confirmed this and noted that accountability for partnering extended to stewards: "Some of the managers have stepped down and they're no longer working at Kaiser. And some of the stewards were encouraged very strongly to conform or to step away from it. . . [Upper level management has] tried very hard to get all the managers on board with this."

Similarly, Cynthia Finter, Northwest Regional President, had made clear to managers in the region that partnership is not optional. And managers who have not embraced partnership have left the organization including managers at **Sunnyside**. As noted earlier, this is a key reason why Partnership activities now appear to be diffusing steadily in this region.

The same degree of accountability is not yet present in other settings we studied. For example, a key difficulty confronting the work place safety (WPS) initiative in **Southern California** was its low visibility in the management control system. One manager involved in this initiative illustrated the problem as follows:

> "If an employee is having trouble typing because of poor workstation design, a new keyboard tray is an expense, and the manager is worried

about that expense. But if the employee is injured, the resulting workers' compensation bill is not on the manager's budget. The manager can replace the employee with a temp at the same budget cost to the manager. Workers' compensation is buried in overhead. It is identified only down to the medical center level and it's slow to reflect improvements as it's calculated on a three year moving average.

But our workers comp expenses have sky-rocketed in the past five years, and that has put it on leaders' radar screens. So now, the Service Area and Medical Center injury rates are reported monthly to top Regional management. Which is great. But WPS is just one of 14 or more management priorities -- which means it's no priority at all. Yes, LMP and WPS are now part of the service area managers' variable pay, but so are dozens of other priorities. And down at the department level, nothing has changed -- department goals are rarely connected to national or regional or even service area goals, and to the extent they are, WPS is still just one of many priorities.

The way I see it, WPS requires a major culture change, but management has not seriously committed to making that change happen. We put WPS under LMP, and then rolled LMP out as a parallel structure. As a result, neither LMP nor WPS have been integrated into management's daily concerns. They are "dressing on the side" of the salad.

Finally, now, at the end of 2004, top leaders are stepping up to the plate to lead this culture change. But it's getting late in the day."

Accountability is equally important for union leaders. In the **Fontana Medical Center**, for example, a labor-management team worked very hard to develop a strategy for improving patient access only to have their idea scuttled at the last moment when a union steward indicated that he could not agree to the changes in work processes required.

As noted above, SEIU is holding its stewards in **Fresno** accountable, both for follow through on partnership activities and other steward responsibilities. A Chief Steward described the process in this way:

"We had some shop stewards who were not participating, were not meeting the requirements of the [union's governing board]. They had an opportunity to come and either reaffirm or give reasons for why they weren't attending meetings and giving good representation to the union representatives and they were either voted back in or asked to step down."

This quote suggests that labor representatives, like their management counterparts, have to see their elected or appointed positions as at stake if they do not support and engage the Partnership.

In the **Northwest**, labor accountability follows from the inclusive role labor has been given in managerial structures and strategy development. Cynthia Finter, Northwest Region President, views labor's accountability as part of the partnership learning process:

> "I've never felt any resistance to being accountable. I've never felt any reluctance to do the hard work. It's just a question of figuring out what it means to be accountable."

Physician accountability is equally important, but as the example below suggests, has been hard to achieve in some regions.

> "The concept of LMP is stellar. But in practice, it's been a struggle. As nurse anesthetists, we work very closely with physicians, but the physicians are not required to take LMP training and are not held accountable for their partnership behavior. It is as if one leg of the three-legged LMP stool is missing. The department is always out of balance."

Holding management, labor, and physician leaders accountable for supporting, implementing, and achieving results with the Partnership sends a clear and powerful signal that this is what is expected of all leaders.

Capacity

Capacity refers to the extent to which the parties have the skills, knowledge, time, and resources to engage in Partnership activities and still ensure that their other work gets done well. One of the biggest capacity challenges lies in training union, management, and physician leaders in how to engage and do their work effectively and efficiently in ways consistent with partnership principles and processes.

Training

An enormous amount of training has been carried out since the Partnership was created. Most of the training focuses on educating managers and labor leaders on Partnership principles and processes. Little of the training, however, has focused on basic business and/or health care service delivery or patient care processes. As a result, it has been difficult to engage physicians in the training being offered and reinforces the perception that the Partnership is mainly a labor relations activity and not an integral part of KP's health care delivery process.

This can be seen from the data obtained in an Implementation Survey conducted in 2003 and 2004 by the Office of Labor Management Relations. These data are reported in Figure 3. The results indicate that *LMP Orientation* training has reached at least a majority of employees, stewards, and managers in all regions. Training on specific Partnership processes such as *Interest Based Problem*

Solving and *Issue Resolution* is more variable across regions but again has reached a majority of stewards and managers in most regions. Training on *Corrective Action* is even more variable, as is training on basic union and management Partnership leadership skills (*Managing in a Partnership Environment* and *Union Partnership Representative*) (MPE and UPR).

Across the board, physician participation in training is very limited, ranging from essentially non-existent for Partnership leadership, *Corrective Action*, and *Issue Resolution*, to a high of 32% for *LMP Orientation* in Northern California. These data confirm a point made in our first report: Physicians are reluctant or unable to take the time to engage in training for generic LMP processes. To engage physicians requires demonstrating that the LMP processes can help improve the delivery of patient care.

While these data suggest that the amount of LMP training carried out is indeed impressive, it is difficult to determine from the data available whether KP is allocating as much time and resources to on-going training as do other large employers that have committed to being leaders in quality in their respective industries. The American Society for Training and Development estimates that the average American firm spent approximately 2.52 percent of payroll on training in 2003. Among the companies the ASTD cites for their leadership as learning organizations this percentage rises to 4.16 percent.[3]

Some companies and unions such as Boeing and the International Association of Machinists and Aerospace Workers, Ford, GM and the United Auto Workers, various telecommunications' companies and the Communication Workers of America, have set up joint training programs funded by an amount set aside per hour worked. These programs have the advantage of providing funds that are not dependent on annual budgetary pressures and provide employees and local leaders more opportunities to choose training programs that fit their specific career development and operational needs.

A joint fund would be one way to broaden the array of training opportunities available to the workforce and local leaders at KP and to tailor training to better fit the career and organizational needs.

[3] 2004 State of the Industry Report, American Society for Training and Development, http://www.astd.org/astd/research/research_reports.

Figure 4
LMP Sponsored Training

	LMP Orientation				Interest Based Problem Solving			
	Employees	Stewards	Managers	Physicians	Employees	Stewards	Managers	Physicians
No. Calif.	67%	88%	85%	32%	33%	65%	64%	20%
Colorado	67%	63%	79%	12%	52%	55%	83%	20%
Northwest	51%	73%	79%	0%	16%	65%	69%	0%
Ohio	85%	92%	95%	10%	42%	86%	87%	2%
So. Calif.	59%	61%	75%	8%	11%	52%	68%	2%

	Issue Resolution				Corrective Action			
	Employees	Stewards	Managers	Physicians	Employees	Stewards	Managers	Physicians
No. Calif.	14%	33%	33%	3%	10%	30%	29%	3%
Colorado	45%	42%	64%	9%	57%	62%	83%	6%
Northwest	12%	58%	55%	0%	7%	43%	84%	0%
Ohio	76%	87%	90%	9%	82%	88%	91%	9%
So. Calif.	32%	52%	71%	1%	9%	54%	71%	1%

	UPR Training		MPE Training	
	Employees	Stewards	Managers	Physicians
No. Calif.	8%	15%	4%	0%
Colorado	27%	64%	44%	0%
Northwest	5%	63%	27%	0%
Ohio	70%	87%	68%	2%
So. Calif.	4%	43%	1%	0%

Engagement

LMP leaders define engagement to mean that "employees are meaningfully and effectively involved in Partnership processes to identify problems and solutions, and to implement those solutions." Successful engagement begins with having appropriate structures and processes for Partnership interactions to take place. It also requires effective skills in leading joint labor-management teams and meetings. Finally it requires that those involved in Partnership activities have appropriate support or backfill to carry out their other responsibilities.

<u>Structures</u>

One of the chief accomplishments of the Partnership has been the building of a joint infrastructure at various levels. Yet creating an efficient and integrated and coordinated set of structures in as complex and decentralized an organization as KP has proved to be very difficult. Both the KFHP/H and the Permanente Medical Groups have long traditions and cultures that reinforce decentralization of authority, autonomy of regions and medical centers, and a division of responsibility and authority between physicians and managers. Implementing a program-wide initiative like the LMP is bound to and has in fact experienced difficulty, given this decentralized culture and structure. Thus, the LMP structures have evolved and adapted in various ways and continue to vary across regions.

Whereas much of the activity in the early years of the LMP was at the national level, through the National Labor Management Partnership Strategy Group and its precursors, the National Partnership Council and the Senior Partnership Council, more recently LMP steering committees or councils have been established in virtually all the regions, at many facilities and in some cases even at the departmental level. In fact, in 2004 there was a conscious effort to shift LMP resources to the regions and the Strategy Group, (the successor body to the early national bodies listed above) is being de-emphasized and is meeting less often. While some regions are still working on putting this infrastructure in place, others are moving past the parallel structures and integrating labor directly into managerial operations committees at both the regional and facility levels. For example:

- **Southern California** has had a regional council for some time along with Service Area councils but is not working to put in place facility based structures. However, **Baldwin Park** is one facility in this region that has a robust steering committee leading the creation of department based teams throughout the Medical Center.

- **Ohio** also has a stable, functioning regional council.

- The **Georgia** region created a regional LMP steering committee in 2004.

- The **Northwest** region disbanded its regional council and instead has partnered all mid-level managers with stewards from their partner unions and labor representatives participate in the regional Medical Operations Leadership Team. This integrative approach extends into at least some facilities. For example, the **Sunnyside Medical Center's** CEO's labor partners are now members of the Hospital Operations Tracking Team.

- **Northern California** and **Colorado** are following along a similar path to the Northwest, having recently disbanded their regional councils although it is not clear what will replace them.

Similar variation is observed at the Service Area level. LMP councils are active at the Service Area level in most of the regions. In **Southern California** these operate parallel to rather than a part of the management structures present at this level while in the **Northwest** labor and management leaders function as partners at the Service Area level.

The development of departmental teams is much more spotty in all regions. Even in the Northwest where partnership is moving quickly toward an integrative approach, the transformation of Unit-Based Councils into departmental LMP structures at **Sunnyside** has gone slowly. In much of **Southern California**, though **Baldwin Park** is a notable exception, there has been very limited movement toward departmental level LMP structures. While there is widespread discourse about the need for rank and file engagement, it is not clear whether there is consensus that departmental LMP structures are the vehicle for that engagement.

Despite the extensive development of joint structures, at least at mid to upper levels of the organization, problems remain. In some cases, the LMP structures at different levels are not themselves integrated. This is particularly a problem in the large complex Southern California region. There the membership of the regional LMP council does not include representatives from the Service Area councils and so it is difficult to assure an on-going flow of information across these bodies. Instead regional and service area council members have met to coordinate their activities from time to time around specific issues.

Similar problems exist at the local level in some cases where there is a lack of coordination across department-based teams within a Medical Center. This was the case in the Joint Staffing effort at **Sunnyside Medical Center** in the Northwest. The facility-wide oversight committee failed to function and so did not provide an adequate structure for dealing with inter-departmental issues. Some facilities are addressing this issue. **Fresno**, for example, brings both departmental and project teams together in their monthly LMP meetings.

LMP structures that are parallel to regular operational management structures tend to reinforce the idea of partnership as a labor relations "program", not an operational strategy. The **Northwest** is clearly and deliberately moving away from this model at all levels. Other regions may be moving in that direction, albeit much more slowly and some, including **Southern California**, are not heading there at all.

The Partnership faces a different type of structural challenge as it moves forward with the membership marketing initiative. After trying joint marketing committees at the service area and regional level, **Southern California** determined this was not a useful approach, and the regional committee was disbanded. Other regions have experimented with labor advisory groups, which is a very different model. The National Marketing Strategy Workgroup convened in 2003 (and described below) was the first national forum where labor, through

the participation of CKPU's Marketing Director Tim Gray, engaged in developing a marketing strategy to expand KP's membership. This involvement was not through a "joint" Partnership structure – Gray was the only labor member of the group. But he played a central role in its deliberations. In its report, the Workgroup acknowledged "that there is work that needs to be done in terms of clarifying roles and processes among Coalition members, local Labor leaders and KP Sales & Marketing staff." One of the challenges facing KP's new National Labor and Trust Fund Director Chris Blass is devising "the optimal structural way for sales and marketing to interact with labor."

Two other sets of partnership structures that have grown substantially are the Office of Labor Management Partnership and the Coalition of Kaiser Permanente Unions. The two organizations have grown from a handful of staff in each organization to a current roster of 56 people. Along with this growth has been significant improvement in both the structuring and accountability of the support staff in both offices. In late 2003 the staff was reorganized so that paired labor-management teams were assigned leadership of partnership activities in each region as well as of national priority areas (e.g. Workplace Safety) and support functions (e.g. Measurement). In 2004, teams submitted work plans for the year including measurable goals; teams then reported back on their attainment (or lack thereof) of those goals at the end of the year. Finally, there is a "regionalization" process going on whereby many of these staff, especially the project and communications consultants, are assigned to particular regions.

Integrating these structures across levels and within management bodies and processes is a complex challenge, but one that needs to be met if management and labor representatives are to be held jointly and individually accountable for using Partnership principles in carrying out their everyday duties. At the same time, keeping the structures as simple as possible and the number of meetings required to coordinate them as few as possible are also critical to avoid replicating in the LMP the maze-like complexity that slows decision-making in parts of KP.

<u>Leadership of Team Meetings</u>

The Partnership has engaged large numbers of people in meetings at all levels of the organization, with the aim of working as joint labor management teams to accomplish common goals. For example, at the **Baldwin Park Medical Center**, the Partnership's decision to involve labor and management in all departments has expanded the number of people involved, and the number of meetings that take place. There are approximately 38 chartered Department Based Teams (DBT), with membership in each ranging from 3 to over 20 (more than 350 members in all), meeting at least monthly (some bi-weekly), in meetings scheduled from an hour to a half day. This amounts to an investment in DBT meetings each year of thousands of person hours. And this does not include the substantial time spent in meetings of the Baldwin Park LMP Steering

Committee, team projects (for example, in 2004 developing an Attendance Toolkit, drafting a dress code, and an ambitious service improvement initiative), in Partnership activities at the Service Area and Regional Level, preparing for meetings, and any follow-up to the meetings.

The scale of this investment at Baldwin Park and elsewhere, and the importance of getting things done, require that team meetings be effective. Skilled team and meeting leadership is critical to deriving value from this investment.

At Baldwin Park the meetings are jointly chaired by labor and management. The external skilled facilitation that was available to the joint labor management project that designed the Hospital, and to the Baldwin Park Steering Committee when it was being formed in 1999-2000, has not been a resource available to these teams. As a creative substitute, the Steering Committee decided to assign its members to "coach" the DBTs, and they sometimes participate in DBT meetings as a facilitator. But their facilitation and meeting management abilities, like the skills of the joint DBT chairs, vary widely. As a result, in some of the DBT sessions observed the participants made progress on the work at hand, adhered to agreed upon meeting norms (for example, beginning the meeting at the scheduled time, being guided by the agenda), and followed Interest Based Problem Solving (IBPS) processes (like consensus decision making and brainstorming) well. But others did not. Two examples illustrate the difficulties when team meetings are not skillfully led.

First is a meeting we observed where there was confusion over whether participants had made a decision:

> At one DBT meeting, consternation about a supervisor rotation plan revealed that the manager, who was preparing to implement this plan, erroneously believed that the DBT had agreed to do this at a prior meeting. The idea of rotating supervisors had been raised at the prior meeting as a "suggestion box" comment. No one had indicated they saw problems or objected, and so the manager explained she thought the DBT decided it should be done. In her view, it was up to the DBT, not something to be imposed by management on the department: "If the DBT agrees to not go forward with this change, that's what we'll do." But it obviously had not been clear to the team members who had participated in the prior meeting that there was a proposal to be discussed and decided.

We observed a number of situations where brainstorming and other IBPS tools were effectively led by DBT chairs. But there were others where this did not happen. For example, in another meeting observed, the team missed an opportunity to make progress using these tools.

> A problem that was not on the agenda was raised and surfaced considerable tensions between the day and night shifts working in the department. An unstructured discussion revealed that each shift was

> critical of the other, complaining heatedly about the work remaining to be done when their shift starts. There was substantial disagreement about the work that actually gets done during the two shifts, and considerable uncertainty about respective job descriptions. Some solutions were suggested. However, rather than use the DBT as a forum for problem-solving, or at least for clarifying the differences in what each shift perceived to be the facts, the discussion was simply shut down when a manger said she would bring the problem to a future full-staff meeting. There was no progress made, despite a fair amount of DBT discussion time devoted to this. The meeting's leadership did not attempt to channel this discussion more productively.

While these are just two examples taken from the many meetings we observed, they illustrate the critical importance of effective leadership and meeting management skills. The MLE training has been developed to address this need, however, it focuses more on teaching appropriate "Partnership behaviors" than on providing training in generic leadership and team management skills, and it is a program for managers, not for labor co-chairs. In addition, this and other OLMP training programs do not provide support for reinforcing and strengthening skills as they are practiced.

For the Partnership to produce substantive results and to avoid the frustration that builds up when people believe that meetings are not worth their time, more and better training in these generic team leadership and management skills will be needed.

Backfill

Given all the forums and committees that the Partnership has spawned and given the operating guideline adopted by the unions at KP that a formally designated union representative (usually a steward) be present at all of these joint meetings, the need for backfills frequently arises. In some instances the first hurdle is budget, finding the resources to pay for the replacement.

A chief steward comments on the challenge:

> A big job for me is making sure that departments are staffed appropriately so that people can get released to do the Partnership meetings they have, whether they be cost-savings meetings, or budget meetings, or just plain labor-management steering committees or departmental meetings, whatever. And there has been some commitment on the national level that there is going to be a special fund, so the money to pay for their release time to go to these meetings is going to come out of that. So the individual department doesn't have to carry the price of paying for the replacements.

But in most instances the big issue is having the absence of the union representative from the department (with a replacement) not affect the quality of patient care. A business agent put the problem as follows:

> When a steward is participating, it is very difficult to backfill because patients feel uncomfortable interacting with them in the delivery of services. Then there's a pushback from colleagues who wonder why the steward was allowed to go to a meeting and ended up creating an extra workload for them.

And for the union representative a number of issues are present, both in picking up the loose ends back in the department as well as insuring that colleagues are briefed about the work of the committee. The words of two stewards capture these issues:

> I have two voicemails that I have to pick up so those don't get answered. So I come back from my meeting and sometimes I'm here until 7:00 p.m. doing that stuff.

> I find it very difficult to walk into the departments and get a chance to actually talk with the staff. They are just SO busy with patients. It gets very difficult to have those small group discussions with them about what the Partnership has done, what the Partnership is working on, what are our goals for the year or next year, and how we see us getting there.

This issue can create significant disconnects between stewards or other labor participants in partnership activities and their coworkers. This was evident in many of the projects we studied. For instance, while participants in the Joint Staffing Committees at **Sunnyside Medical Center** in the Northwest expressed a lot of satisfaction with the process, their non-participating coworkers were not so sure. In a survey done in units that had undergone a Joint Staffing process non-participants made the following suggestions on how to improve the process: "Maybe regular meetings to better inform staff...of how the project is going." "More people involved." "More communication with everyone on what is going on." It should be added that committee representatives felt they had made serious efforts to communicate back and yet their peers were still unhappy.

Management and labor leaders in the **Northern California** region have made a conscious effort to address the backfill issue and appear to have made considerable progress. A recent survey of stewards in a large local union in the region found that a majority (61%) did not find it hard to get away from their regular jobs to perform their partnership duties.

The experience with ARG I and ARG II in Ohio indicates that active communication with members can help alleviate some of the concerns employees have about the time their representatives spend on Partnership duties. During

ARG I a number of employees voiced resentment with the extra duty they were asked to cover for employees who were absent for up to two weeks without any feedback. By the time ARG II occurred in 2004, however, there was a clear picture of what was happening and the meetings were limited to two days and then representatives returned to their work groups and were available to respond to questions.

Backfill has been a constant concern to labor and management leaders since the inception of the Partnership. Progress has been made in dealing with this issue in some regions and settings, but it remains a significant concern in many locations. Providing the needed staffing to compensate for time devoted to Partnership activities will be critical for the Partnership to be viewed in a positive light by employees, physicians, and managers on the front lines of delivering patient services.

Results

Lack of Good Performance Measures[4]

One of the most frustrating aspects of conducting this research has been our inability to obtain reliable and valid measures of the substantive results of specific partnership projects on patient care and workforce interests. Particularly difficult to collect were process and outcome measures at the department and facility level. To their credit, the leaders of the LMP have tried, from the very beginning, to build measurement and evaluation into the partnership. One of the first committees formed in 1997 was the Metrics Committee, which exists today as the Performance Measurement Committee. With joint labor and management sponsorship and leadership, this committee of measurement experts drawn from KP and the Coalition has identified key metrics and evaluation methodologies. Additionally, there has been a full-time staff person in the LMP dedicated to measurement since 2003.

Thus, we take the absence of system-wide outcome data as a substantive finding. While there are multiple specific reasons why system-wide data are not available and why efforts to collect appropriate standard measures have been unsuccessful to date, we believe the root cause of this lies in the decentralized tradition, culture, and structures of KP. There is no single set of metrics to which everyone at KP is held accountable for meeting so it is not surprising that efforts to collect common performance data eventually run up against cultural or political barriers. Thus, no one in either the KFHP/H or the Permanente Medical Groups has the power to compel everyone to provide common data to a single central body or functional group. Consider the following examples:

[4] One of the authors of this report, Adrienne Eaton, has also served since 1998 as an external consultant to first the Metrics Workgroup and now the Performance Measurement Committee."

Improving attendance was identified as a high priority item for the Partnership in 2002. It was found that all regions track attendance differently, if at all. By early 2004 labor and management leaders on the National Attendance Committee had agreed to a common definition. Yet by the beginning of 2005 only one region was able to collect data using this definition, and that region was still not able to incorporate results into their reports. Similarly, the measurement group identified workforce measures for the goal of "employment security" which included the number of represented employees redeployed, retrained, voluntarily and involuntarily laid off and retired as a result of job elimination or reclassification. These critical variables are still not being reported by Human Resource departments in the regions.

Efforts to relate the level of implementation of the LMP to various outcome measures have also been difficult. A survey of facilities was undertaken by the OLMP in late 2003 and early 2004 to determine the level of LMP involvement at KP facilities, medical centers, and regional departments. Useful results, referred to in other places in this report, were obtained for some regions, but others did not participate or participated in ways that made the information less useful. Facilities without basic labor/management structures were far less likely to fill out the questionnaire. Mid-Atlantic States and Georgia regions had minimal participation because their LMP leaders felt Partnership wasn't "sufficiently advanced" to measure in their facilities. Southern California opted to complete the survey at the Service Area level, masking significant facility, medical center, and department variation.

Regions have a strong desire to customize survey questions and processes to meet their particular needs and are often allowed to do so. While this builds support for measurement initiatives, because regional representatives can help to shape measurement tools that are useful to the region, it undermines the ability to create standard, program-wide measures that are directly comparable to one another and that are needed for quantitative analyses.

Data and measurement problems can also be seen in the case studies. For example the Joint Staffing committees at **Sunnyside** all identified specific outcome measures they planned to track as part of their staffing plans. While in some cases, committees did track and report back on these measures, in other cases, they found a given measure did not exist at a level or for a time period that was useful or was too contaminated by factors other than staffing to be useful.

Efforts to attach dollars for both costs and benefits to LMP activities have also not gone smoothly. A pilot project to develop a method of conducting a return on investment analysis was begun in the **Northwest Regional Laboratory**. The project was well advanced and the method close to fully developed when the project was put on hold, initially because of restructuring in the region and related changes in management.

The annual employee survey, People Pulse, may be the most uniform data collection taking place in KP. Even there, however, different regions administer the survey during different months (or in some years not at all). Further, the typical sampling strategy does not allow for departmental level analyses to be conducted except in facilities or service areas that have chosen to invest in an actual census. Thus, these data are not disaggregated enough to be easily connected to measures of the delivery of patient services in a fashion similar to production or service delivery models in other industries (e.g. Sears model; Southwest Airlines; Toyota, etc). Beyond these problems, the raw data have thus far been inaccessible to OLMP measurement staff and to our research team, making it impossible to do the types of specific analysis needed to relate Partnership involvement to other employee views of their work environment or to performance outcomes in specific units or facilities.

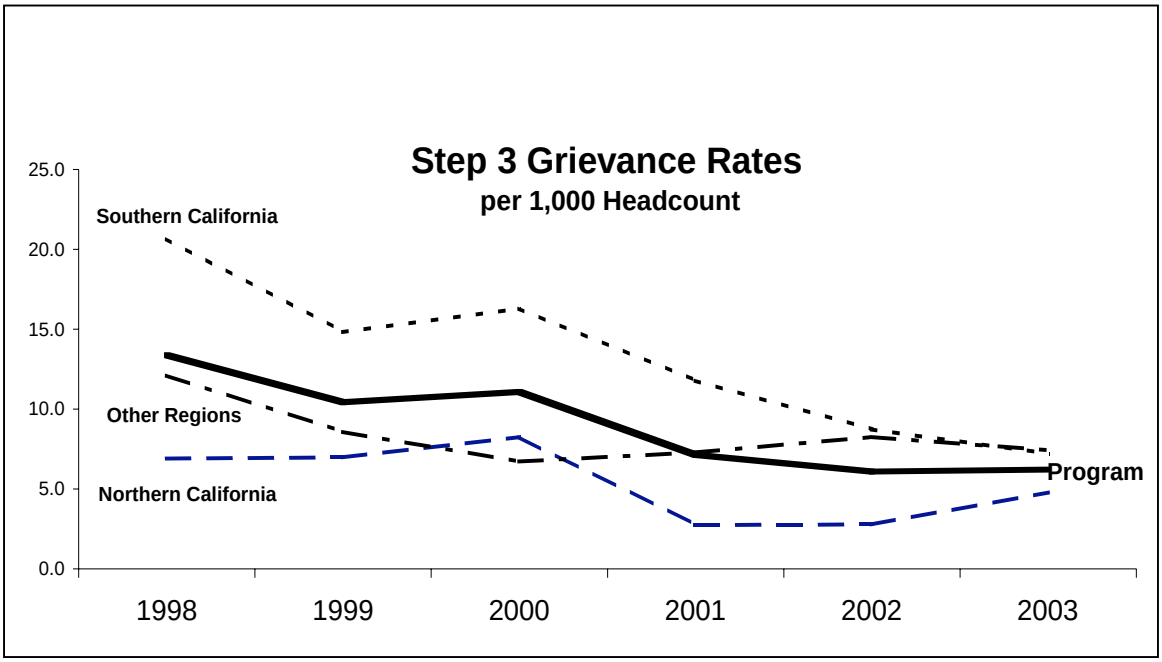
Given this experience one might ask: Will it ever be possible to collect data on a system-wide basis to either track performance on a small common set of key metrics or to assess the effects of Partnership activities on these outcomes? We believe it is not impossible but to do so will require agreement on a set of common, critical performance measures. Unless this is done, KP will not be able to demonstrate the contributions the Partnership is making to the delivery of health care delivery or demonstrate the relevance of its approach to the larger debates underway over the U.S. health care system.

While the lack of needed data does not allow us to draw specific associations between Partnership activities and performance outcomes, several system-wide data sources do provide data that track performance on several key outcomes over the time period that the Partnership has been in place. We review several below.

Grievance Rates

Figure 5 shows the steady decline in Step 3 grievances since the beginning of the Partnership. In 1998 KP experienced approximately 15 Step 3 grievances per 1,000 employees. The most recent data available indicate that in 2002 this rate had declined to slightly more than 7 per 1,000 employees. Correlating these data across regions shows that the lower the grievance rate the higher employees rate KP as a good place to work, a result that is consistent with other studies of the relationship of grievance rates with job satisfaction.

Figure 5



Employee Views: People Pulse Survey Data

KP conducts a system-wide mostly standard employee survey called "People Pulse" periodically; the survey has included two questions about the Partnership since 1999. These data have shown a steady improvement in, among other things, employee views of KP as a place to work, a good place to get health care, satisfaction with job security, and knowledge of and involvement in Partnership activities.

2004 survey data show that Program-wide, 47 percent of union respondents indicate knowledge about Partnership activities and 39 percent indicate they are personally involved in one or more Partnership activity. Both of these represent increases of approximately 20 percentage points since 1999. Managers and supervisors report higher involvement rates than other employees. Fully 77 percent of managers indicate they are involved in Partnership activities. These numbers represent a significant growth in the reach of the Partnership in recent years.

Involvement in the Partnership is also positively correlated with a range of other employee views of their job and their influence over issues at their workplace. Figure 6 lists the questions in which involvement in the Partnership is associated with significant difference in views. Clearly, involvement in the Partnership is associated with a better understanding of what is going on in the organization, stronger identification and agreement with these goals, how employee efforts

contribute to meeting these goals, and with a feeling that employee ideas are being put to use.

Figure 6
People Pulse Survey Data 2003
Union Represented Employees

Features of the Work Environment Percent Agree or Strongly Agree

	Not involved in LMP	Involved in LMP
Know about department goals	53.2%	80.6%
Know about KP Mission/Vision	48.7	76.1
Understand how work fits org's goals	64.6	87.5
I agree with organization's goals	55.3	82.3
Trust information from leaders	43.3	75.1
Can influence decisions affecting work	15.0	48.7
Mgt uses good ideas employees have	28.4	67.4
Recommend KP for health care	70.2	91.2
Recommend KP as place to work	66.5	90.5

Do these improving attitudes contribute to better patient care? Unfortunately, the data needed to test for this relationship do not exist at KP. However, other studies of service industries from retail sales to airlines have shown that positive employee attitudes about their job and their employer are associated with positive customer satisfaction and other measures of service quality. The most specific quantitative estimate of the size of this relationship comes from studies conducted at Sears. Based on years of data from their employee and customer surveys they estimate that a 5 point increase in employee satisfaction is associated with a 1.3 point increase in "customer impression" which in turn is associated with a 0.5% increase in revenue growth.[5]

Our own research in the auto and airline industries demonstrated similarly strong associations between the quality of labor management relations (low degrees of conflict in negotiations and positive workplace climate) and product or service quality (number of product defects in autos and number of customer complaints and lost bags in airlines)[6]. While we do not have sufficient data to conduct a similar analysis of the effects of changes in employee attitudes, patient

[5] Calculations provided by Office of Labor Management Partnership

[6] Harry C. Katz, Thomas A. Kochan and Kenneth Gobielle, "Industrial Relations Performance, Economic Performance, and QWL," Industrial and Labor Relations Review, Vol. 37, 1983; John Paul MacDuffie, "Human Resource Bundles and Manufacturing Performance: Organizational Logic and Production Systems in the World Auto Industry," Industrial and Labor Relations Review, Vol. 48, 1995, Jody Hoffer Gittell, Andrew vonNordenflycht, and Thomas Kochan: "Mutual Gains or Zero Sum: Labor Relations in the Airline Industry," Industrial and Labor Relations Review, Vol. 57, January, 2004; Jody Hoffer Gittell, The Southwest Airlines Way, New York: McGraw Hill, 2004.

satisfaction or quality of care, and financial outcomes with the KP data, all these indicators are moving in the same direction in recent years. Again, however, we cannot estimate how much if any of these improvements are a result of the spread of Partnership activities. These are the types of micro-level data that we urge be collected and reported on a program-wide basis. If combined with reliable measures of the cost of Partnership activities, a return on investment estimate could be made.

Financial Performance

KP has enjoyed steady improvements in operating margins during the years of the Partnership. Operating margins were -.2.3 % , 1.0%, 3.3%, 3.7%, 0.6%, 3.9%, and 5.7% respectively for the years 1998 through 2004 (through the 3rd quarter for 2004). Again, however, these results reflect many factors; the portions, if any, due to the Partnership cannot be isolated.

Safety

Partnership leaders, KP senior executives and physician leaders, and the KP Health and Hospitals Board of Directors have all identified safety as a high priority for improvement. Progress, both as measured by injury rates and as reported in our interviews has been slow and variable across different regions and facilities. The most recent data show that among the regions with hospitals (where injury rates are significantly higher than in clinics and other non-hospital health care facilities), the **Northwest** and **Northern California** experienced reductions in reported injuries while the injury rate remained constant in **Southern California**.

One of the most frequent sources of injuries in hospitals is lifting patients. KP has a well developed "lift team" program. Facilities with lift teams in place report 37 percent lower injury rates.

KP has recently increased the emphasis and the resources devoted to improving safety. The KP Board of Directors has made a special allocation to promote a new safety program and created and filled a new position for Vice President of Safety. A new Comprehensive Safety Management Program modeled after benchmark safety management programs identified by DuPont safety consultants is now being piloted for widespread implementation. Management compensation will be tied to safety performance in 2005. Thus, on this issue, KP may be poised to make significant progress. To do so, however, will require overcoming the barriers to implementing national priorities observed in other areas.

Attendance

KP identified attendance as a national concern and in 2003 created a national Attendance Committee to address this issue. Medical Group leaders in Southern

California have consistently raised this as a serious concern, citing absenteeism levels averaging between 12 and 13 percent in the past two years.

Two staff people full-time dedicated to supporting the effort. They had developed a list of the "Root cause factors of absenteeism" that is organized under three headings:

1. Environment: Workload volume, work intensity, stress, injury, inadequate tools, LMP responsibilities, work avoidance, FMLA, etc.

2. Relationships/personal issues: Poor morale, poor management-staff relationships, poor staff-staff relations, child-parent-animal care, domestic issues, technical (car etc), emotional-physical illness, death of loved one, fatigue, top down management style, generation difference in work ethic, feeling of entitlement, work inequities.

3. Staffing/scheduling: Overtime-burned out, time off denied, combine holiday-weekend, avoid floating, vacancies – short time, school-classes.

Opinions as to how to work on attendance seem to be divided between those who see the attendance problems as due to employees' poor work ethic, those who think it is due to the unions' defense of lazy workers, those who think it is due to ineffective managers, and those who see all these as interconnected. A number of pilot intervention programs have begun, agreement has been reached by the national committee on a common definition of absenteeism, and efforts are underway to collect data using this common definition. To date, however, none of the regions have made significant progress or met their annual target for reducing absenteeism.

Some union leaders are reluctant to be involved in this initiative. They hear some members questioning, for example, "Why is my union in cahoots with management" on this issue? Moreover, despite high rates of absenteeism in some regions and facilities, there has been insufficient management "pull" on this issue. Other priorities such as workplace safety appear to be getting more support and resources both from national and facility-level leaders.

The following summary of a report to the Attendance Committee of the Attendance initiative at the **Inland Empire Service Area** in Southern California illustrates the complexity of this issue and the difficulties parties have experienced in trying to address it.

> In one nursing unit, the managers complained that was no budget this year for offering gift certificates for perfect attendance, in the past that had helped a lot. The department administrator has not had time to meet regularly enough with people who have attendance problems. The data are often bad, so the managers don't really know enough about employee's

record to have a well-informed discussion of their record. They have a hard time moving the Corrective Action process ahead because they can't get a union representative to attend -- there are not enough of them.

In a call center, the attendance problems appear to be due stressful work, in particular, dealing with irate patients. Many callers become irate because it is so hard to get appointments. A council member commented that management is treating this as an entry-level job when it should be staffed by experienced people. This leads to the combination of inexperience and job stress which in turn leads to absences, turnover, and thus more stress, etc. in a vicious cycle.

The implication of this example, and others like it, is that attendance issues cannot be treated in isolation. They are partly a reflection of the overall work environment.

Joint Staffing

Staffing is a core issue in the healthcare industry including at Kaiser. Health care workers and unions have concerns about staffing levels that are reflected in their demands at the bargaining table and in their policy proposals, particularly at the state level. KP employees share these concerns. According to CKPU's 1998 survey of union members 61 percent of respondents disagreed with the statement "Staffing levels at Kaiser are adequate." At the same time, staffing complaints are often proxies for broader problems in the organization of work and work systems.

As a result, KP and CKPU have jointly focused attention on staffing as an important issue. In 2000, the parties bargained a joint staffing process as part of the national agreement. The language calls for a broad joint effort: "The process should be applied across the program in all areas where employees represented by partner unions work." To get the process moving, the parties agreed to use national LMP funds to support pilot projects in each region. The Northwest pilot was done at Sunnyside Medical Center and is one of the cases we studied.

As time went on, CKPU found itself over-extended and unable to set guidelines or parameters for the pilots or to fully support them, in a resource sense. With regions encouraged to experiment, the pilots themselves lacked coherence. Some focused on a particular occupational group (nurses in **Southern California**) or facility (as in the **Northwest**) while others attempted a broader rollout (**Northern California**). Even where staffing plans were jointly developed they were often not implemented. This was true at **Sunnyside** as elsewhere. In addition, at Sunnyside, the parties failed to deal with the larger systemic problems that often led workers to feel that their units are short-staffed. At the same time, smaller scale changes in departmental practice were made and a few positions were added. There is little evidence of significant improvements in the outcomes that were tracked by the unit teams; at Sunnyside the most significant measurable improvement came from the Emergency Department which greatly

reduced the number of patients diverted to other hospitals thus saving KP substantial sums of money. Sunnyside People Pulse results for the question most closely related to staffing showed sharp improvements for one department that went through joint staffing, sharp decline for another and not much change for most.[7]

Over the course of 2003, it became clear that CKPU did not have the capacity to staff all of the partnership projects that were launched or slated to be launched. In particular, the coalition concluded that it simply could not give staffing the attention or resources it needed and so, with concurrence of the member unions and with KP, the joint staffing process was taken off the list of national LMP priorities. The Coalition continues to encourage local unions to pursue staffing issues using LMP tools including Issue Resolution and Interest-Based Problem-Solving. Program-wide People Pulse results suggest that progress is being made on staffing or at least on the perception of staffing problems in some regions.

Three regions, the **Northwest** and both **Northern** and **Southern California** showed steady improvements in the percentage of union represented employees reporting agreement that "There are enough people in the department to do the job well." In **Northern California**, for instance, that percentage increased from about 30% in 2000 to 50% in 2004. Similarly, a 2004 CKPU survey found that 45 percent of union respondents disagreed with the statement that "staffing levels are adequate at Kaiser" compared to the 61 percent who disagreed with this statement in the coalition's 1998 survey.

Marketing

The commitment by Kaiser Permanente's Union Partners to work with KP on expanding labor membership in the Health Plan is one of the original purposes stated for the Kaiser Permanente Labor Management Partnership. The parties were easily aligned on this goal, As one Kaiser executive commented, "...if we do well, we'll all get benefits...No one has to change the way they manage...unions don't have to change the way they work..." Despite the clear alignment of interests, there was little activity in the early Partnership years, in part because KP's sales and marketing force had no sense of urgency about membership growth, and little confidence that labor could be helpful in marketing.

After the 2000 contract agreement, LMP leadership was increasingly eager to demonstrate the value added to KP by the Partnership, to counter growing management resistance. In addition, there was increasing concern about membership numbers. LMP leadership targeted membership marketing as one of the areas that needed to be ramped up, and CKPU hired a full time Marketing Director, Tim Gray, to get this initiative moving. These were catalysts for convening a National Strategy Workgroup, which devised a national marketing strategy for the labor business line for the first time in KP's history.

[7] The People Pulse question is "There are enough people in my department to do the job well."

Tim Gray's participation in this workgroup engaged CKPU in the center of this strategic work.

A comprehensive system and metrics are not yet in place to measure the results of the joint marketing initiative. However, membership enrollment is reported regularly, and in January 2005, KP grew by 90,479 members. Much of this growth was in strategic and large groups including labor trusts; in the **Northwest** region, there were significant open enrollment gains resulting from collaborative marketing initiatives with UFCW Local 555 and the Plumbers and Pipefitters union. The January figures are important because they reflect the results of the fall open enrollment period when employees are allowed to switch between health plans offered by their employees.

Interviews and reports revealed a number of ways that marketing activities by KP's union partners have produced increased membership. First, KP's unions have been able to open up a direct line of communication to employees who have the option of choosing KP. The resulting increases in enrollment suggest that this may represent "low hanging fruit" for the membership marketing initiative For example:

- Joint marketing material sent to UFCW members during an open enrollment drive resulted in 965 new Kaiser members in 2004, and another 565 added in January 2005. A letter to UFCW members from the union's officers urged them to choose KP as their health plan. In one of the testimonials included with this letter UFCW's collective bargaining director is quoted as saying "The bottom line is, Kaiser Permanente will save you money – without compromising on quality. The more I learn about Kaiser Permanente, the more I like what I see. And they're a great union partner." This marketing initiative, developed by UFCW and the KP Marketing Team, has led to a number of other groups expressing interest in working with KP on a joint communication project.

- A 28% increase (211) in members at Lockheed Martin in Atlanta in January 2005 followed joint marketing to IAM members. After meeting with IAM's local President, KP was able to mail directly to the union's members and attend a number of union hall meetings. The letter was co-signed by CKPU's National Coordinator Robert Hochberger, UFCW's local president, and the state federation president.

Second, KP's union partners have been helpful in selling new accounts:

- Approximately 1,800 new members were added in the **Mid-Atlantic States** Region (2003 and 2004) after a successful marketing effort that included KP union members showing Teamster representatives through one of the medical centers, and a meeting between KP union leaders and

Teamster leaders to talk about union affiliation. The Sales Executive for this account describes KP union involvement as important in helping the Teamsters decide to offer KP as a choice to its members.

- Union leaders have helped KP get "in the door" for new business: In 2003 KP made a presentation for the first time, after trying repeatedly, to the San Diego Hotel/Restaurant workers, after Walter Allen, Executive Director of Local 30, OPEIU spoke to the union. Similarly, KP was able to make its first presentation to Long Beach City, one of the few public employers in that region that doesn't offer KP as an option to its employees, after help from SEIU's David Bullock. In **Georgia**, union partners have opened the door to discussions with two different Trust Funds about offering Kaiser as an option.

Third, joint marketing has helped retain accounts that were in jeopardy. For example:

- When the employer for a long-term account in the **Southern California** region, with about 590 KP members, notified KP it was not intending to renew because of price, union partners talked with SEIU labor leaders. The account was retained after some modifications in Kaiser's offering to close gaps in benefits.

- When **Fresno County** threatened to withdraw, management brought four stewards to the renewal negotiations and they were able, with the help of the Fresno county unions, to keep the business. As Medical Group Administrator and Director of Hospital Operations Corwin Harper commented, "The stewards understand the business, could answer all the questions, and provide valuable insight into the business"

Not all interventions like this by union partners are successful. Descriptions of ones where, despite labor's effort, the accounts were lost underline the importance of product and pricing, and suggest the limits of what labor can accomplish when called in to help after problems arise.

Thus, after a slow start, some substantive results have been achieved, and the experiences suggest ways to make more significant progress. In addition, a number of indirect results have been realized: a carefully designed national strategy for marketing to this segment; training conducted to develop skills to market to labor; and increased confidence on the part of KP sales and marketing executives that the union partners can play a role in expanding membership. With the hiring of KP's first National Director of the Labor and Trust Fund market, the parties are now well positioned to work together to attract new business.

<u>KP HealthConnect and Workforce Planning</u>

> *"The next major improvement in U.S. health care will result from the carefully designed and consistent use of AMR [automated medical records]…It's time for health care to join the rest of the professions in using the computer to directly improve performance. That will be a revolutionary development, and once it has been done well, we will all wonder how we ever functioned without it."*[8]

The changeover from paper to electronic record keeping has become a major development throughout KP. As the quote from George Halverson and George Isham suggests, if done well, the introduction of automated medical records has the potential to improve dramatically the quality and efficiency of health care delivery. And, as they point out, it will change how health care professionals do their work and eliminate the jobs of many people.

KP uses the term "KP HealthConnect" to describe its new generation of information technology. KP HealthConnect has been implemented via a staggered roll out with the regions outside of California leading the way. As the potential impact on jobs became clearer to the parties, the union coalition successfully argued for dedicated labor coordinator positions for each region to work with the management lead for implementing this new technology. Further, the Partnership added a national focus on workforce planning, closely tied to KP HealthConnect. The hope was that workforce planning around KP HealthConnect will stimulate broader efforts within KP.

Maureen Sheahan, KP HealthConnect's Union Coordinator, sees this as an opportunity for the Partnership to move from being a parallel process to one that is directly involved in health care delivery.

> "KP HealthConnect is an incredible opportunity to extend the Partnership into how KP does its business. The coordinators are not paid out of the LMP budget (except for one anomaly). We've gotten the regions to pay for the coordinators out of their [operations] budget, because we're saying this is value added; they're just another member of your team serving an important organizational function."

Early experiences in implementing KP HealthConnect were mixed and provided lessons that the parties have subsequently learned from and are committed to use in guiding future implementation projects.

Colorado was the first region with full time KP HealthConnect coordinators. But in its earliest stages implementation efforts were criticized by some union

[8] George C. Halverson and George J. Isham, Epidemic of Care, San Francisco: Jossey Bass, 2003, pp. 27, 246.

leaders as being too narrowly focused on the technical software side of the new systems. In their view work flow re-design, scope of practice, next generation products, and health and safety were all seen as separate issues. Moreover, union leaders felt the coordinators had little or no contact with union or employee concerns about these issues. This led to considerable frustration.

KP HealthConnect staff indicate that the process for implementing these new systems does incorporate the full range of workforce and work process issues. In their view, while implementation of the new systems may have varied some in the early phases, current and future implementation projects will engage the technology and workforce issues directly.

In **Cleveland** Margaret Crawford, a union representative, was assigned to work on KP HealthConnect at an early stage of its development and implementation. In her view:

> "Partnership involvement is a given. I have been given the opportunity to go behind the scenes and look at KP HealthConnect. It's important that people who use the program help to shape the program. [This includes] every detail down to where the computers are placed in the exam rooms. How the patient comes in and the new program is applied to that patient. What things do we see on the computer when it pops up? How is it configured? What's a better way to configure it? What do we do, now that we see the application?
>
> [Another part of] my job, to put it quite frankly, is to make sure that the system doesn't screw labor**.** I am here to represent labor. The labor-management partnership agreement states that no one will be laid-off. By the same token this Health Connect project is going to take away jobs. It's going to create them also, so my job is to make sure that when any job is taken away that person doesn't suffer and that any training needed to put that person into a new job is adequate."

KP's Director of Strategic Workforce Initiatives Bob Redlo is responsible for leading the LMP effort in coordinating workforce planning for new technologies including KP HealthConnect and the roll out of new products. Redlo agrees that implementation of new technology, training, and other workforce adjustment issues go hand in hand.

> "Nobody affected by the new systems to date has been laid off and we don't expect this to happen. All employees are given job counseling and offered training needed for other jobs that are available. If for whatever reason employees choose not to be trained for the new jobs, they are covered by a new enhanced severance agreement recently negotiated through our LMP effects bargaining agreement. The new 'effects bargaining' agreement

> spells this all out in even more detail as well as the enhanced benefits and assistance to employees that choose to be retrained. KP HealthConnect will use technology to create new opportunity for people. So far all staff, that have chosen retraining and that have learned new skills for our new technologies have been very successful. The new training programs are extensive and have paid off both for KP and its staff."

Crawford's prior experience helped her to recognize the importance of bringing employees into the design and implementation of new technologies:

> I worked at the hospital in Canton. They instituted a computerized charting program in the hospital, which in my opinion was a disaster, because you couldn't go back and read what you charted. You couldn't go back and proofread it to make sure everything was right or that you said the right word at the right time or gave the right temperature or blood pressure. The program came down from management who said, "This is what you are going to get," nobody who was using the program was able to turn around and say, "wait a minute, wait a minute, look at this, I can't read this." Even the physicians were saying, "This is terrible." Hopefully, seeing the [new technlogy], understanding it, and using it, is going to help us shape it.

The job displacement effects of KP HealthConnect will be substantial, especially among those who now handle record keeping. For example, employment in the chart rooms at **Napa/Solano** is expected drop from 90 to 8 positions. The transition will take place in the third quarter of 2006.

Considerable planning is already underway. One of the immediate issues is helping people prepare for transfer to other areas of the hospital while still maintaining enough experienced staff to get the current work done (twelve people have already left the department in anticipation of the introduction of KP HealthConnect). To quote the chart room manager:

> What I tell [employees] is that they should know the keyboard; they should know something about Windows, and some basic computer programs. I have people who work with English as a second language; they need to take some ESL classes.

The employment and income security provisions of the Partnership agreement require the parties to help those displaced by the new technology find alternative work at KP. The management of this adjustment process will be a significant challenge for some time to come and will be one of the more visible aspects of the Partnership at work.

These examples illustrate three basic principles learned over the years in other industries about designing and introducing new technologies, gaining their

acceptance and full use by the workforce, and translating them into performance improvements.

1. ***The hardware and software features of the technology need to be integrated with the organization of work***. Performance improvements are maximized when there is an effective integration of technology, work organization, and workforce knowledge and skills. General Motors learned this the hard way in the 1980s. After spending more than $60 billion on new manufacturing technologies it still found itself to have higher production costs than other American or Japanese automakers. It took the evidence from the New United Motors Manufacturing Company (NUMMI) and other companies to teach GM that the highest productivity and quality results were achieved in plants that effectively integrated new technologies with work system design and other human resource and labor relations practices.[9]

2. ***Those who do the work need to be involved and influence both the early design features of the technologies as well as its implementation***.[10] The Japanese designers of Toyota's world-class production system captured this principle best with the phrase: "Workers give wisdom to the machines." The failure of the re-engineering movement of the 1990s to follow this principle was best captured in the statement of one of its leading proponents, Michael Hammer as quoted in the Wall Street Journal:

> "Dr. Hammer points out a flaw. He and others in the $4 billion reengineering industry forgot about people. 'I wasn't smart enough about that...and was not sufficiently appreciative of the human dimension. I've learned that's essential.'"[11]

3. ***Workforce planning needs to accompany the introduction of new technologies to ensure that those whose jobs are either***

[9] Paul S. Adler, "The New 'Learning Bureaucracy': New United Motors Manufacturing, Inc.," in Barry Staw and L.L. Cummings (eds.) Research in Organizational Behavior, Vol. 10, Greenwich, CT: JAI Press, 1992.John Paul MacDuffie and John F. Krafcik, "Integrating Technology and Human Resources for High-Performance Manufacturing: Evidence from the International Auto Industry," in Thomas A. Kochan and Michael Useem (eds.) Transforming Organizations, New York: Oxford University Press, 1992, pp. 209-226.

[10] Robert J. Thomas, What Machines Can't Do. Berkeley: University of California Press, 1993.

[11] Wall Street Journal, November 20, 1996, p.1.

changed significantly or eliminated are given the opportunity to be retrained and/or redeployed in an equitable fashion.[12]

KP appears to be learning these lessons as it goes along. Given its integrated health care model, it should be well positioned to demonstrate the potential value of information technologies. Following these well established principles will help KP and the LMP to realize this potential competitive advantage.

V. Summary and Future Directions

The conclusions we reached from our research to date are listed at the beginning of this report and our recommendations for ways to address a number of the challenges illustrated in our cases were noted throughout the report. In this final section we will try to put these conclusions in context by reflecting on the prior, current, and potential future of the Partnership.

During its first five years the parties agreed on a set of goals and general vision for the Partnership, negotiated an historic national agreement, and began the task of learning how to implement Partnership principles to solve key problems. Partnership leaders also gained valuable experience in confronting and working through some difficult challenges or what we refer to as pivotal events, such as negotiation of the basic employment security agreement and the transition to a new CEO and management team for the KFHP/H.

In the Partnership's second phase (2002 through 2004) considerable progress was made in training and engaging more employees, union stewards and leaders, managers, and a small but significant number of physicians. Again the Partnership proved to be effective in responding to specific crises, particularly ones involving the need to reduce costs in response to membership declines. Moreover, the large number of new initiatives undertaken during this time period helped to clarify the factors needed to make Partnership projects successful. Our analysis suggests that specific partnership projects have their best chance of being successful when:

1. The parties are driven by a sense of urgency.

2. Leaders share a clear definition of the problem and vision of the goals they are trying to achieve.

3. Management, physician, and union leaders are held accountable for using partnership principles to achieve concrete results.

[12] George P. Shultz and Arnold R. Weber, Strategies for Displaced Workers, Westport, CT: Greenwood Press, 1966.

4. The stresses on time and other resources required to engage in Partnership activities are managed and backfilled.

Attending to these issues will continue to be critical to the success of specific Partnership projects or initiatives. Moreover, as in the past the parties face some immediate challenges, or what we have referred to as pivotal events, including the negotiation of a new national agreement in the context of uncertainties and tensions associated with the debates over the future structure of the labor movement and the choice and transition to a successor to Peter diCicco. As in the past, the parties will need to put their Partnership principles and tools to work in meeting these challenges.

Looking beyond these immediate challenges, labor and management leaders have separately indicated their desire to transform the Partnership from being viewed and treated as an effective labor relations tool for responding to problems to become a core value and a defining feature of KP's health care delivery system. We believe this is the next major challenge and opportunity facing the Partnership and therefore lay out steps our research suggests would be needed to make this transition.

Moving from Top Down Partnership Projects to Generic Workplace Partnerships

Most of the activities discussed so far in this report involve labor and management *representatives* working within the standard LMP committee structures and processes, usually on specific problems such as cost reduction, improving patient access, workplace safety, etc. Projects like these can serve as a launching pad for more direct use of partnership principles by managers, employees, supervisors, and physicians in doing their everyday work and driving continuous operational improvements. However, as we noted earlier, the parties have had only sporadic success in using LMP projects to do this. We see generation of more of these generic workplace level partnerships as the next frontier for the LMP.

Some of this is clearly already going on. In **Southern California**, for example, an initiative called the "Comprehensive Performance Improvement Program" was recently introduced and has gained significant support from union and management leaders. The idea is to create DBTs in all departments in a medical facility, provide them with training resources, and hold them accountable for improving performance using generic partnership principles while leaving the teams to make their own decision on how to interact and what to do. Earlier we described similar use of DBT's in **Baldwin Park**.

These types of activity encourage more bottom-up innovation and change. They allow for more local discretion and therefore will result in more variation in how the partnership plays out. This means that union and management leaders exert less control over the specific structures and processes used to engage employees

and instead focus on monitoring results and holding local leaders accountable for using partnership principles in their everyday work. They also require that managers and employees are trained and skilled in leading and managing teams, meetings, and related participation processes.

This approach also requires collection and review of performance metrics that are critical to the operations involved. These data can then be used to set benchmarks for comparable units and to support the diffusion of lessons learned.

Experience in other partnership and change programs suggests that diffusion of lessons learned works best when done through personal peer networks. Written communications and electronic-based information systems can be useful supplementary tools for promoting learning and diffusion, but there is no substitute for personal networks for building a learning community. Those involved in these efforts need, from time to time, to travel to sister units and team members from units beginning these processes need to be able to visit benchmark setting units to see first-hand how they might adapt practices to fit their particular needs and settings.

America's Health Care Crisis: Threat or Opportunity?

We end this report with a challenge. We believe the full potential of the LMP will only be realized if it helps KP demonstrate that its model of health care delivery can contribute to solving the health care crisis in America.

To put the issue most vividly we might ask: Will health care be the next airline industry? In airlines, the entry of low cost competition and customer resistance to high and complex airfares have produced an industry restructuring resulting in declining market shares, sustained financial losses, and several bankruptcies among incumbent firms and deep cuts in jobs, wages, and benefits for the incumbent workforce.

Health care is facing a similar crisis of rising costs and lack of insurance coverage for an estimated 45 million Americans. Given that some polls show the public sees this as the number one problem in the country, we can expect considerable efforts to address this issue in the near future, especially at the state level as governors and other politicians start building records on which they can run for President in the next election.

This poses both a potential threat and an opportunity to KP and the LMP. The threat lies in the likely growth of low cost insurance offerings that undercut KP products, services, quality standards, and employment conditions. The opportunity is that KP and the LMP have the potential to demonstrate to America that by working together their integrated health care model can deliver high

quality health care efficiently ***and*** support good jobs and careers for health care employees.

As the model of organizational change used in this report suggests, meeting this challenge will require a broadly shared vision of the core elements in the KP health care delivery model and a strategy for leveraging the LMP to drive its success. Figure 7 below is a working draft of what we see as the key elements in this model and LMP's role in it. We present it as a draft for discussion and refinement by KP and LMP leaders and participants. It will only have value in guiding behavior if it is broadly accepted by leaders and employees as the core elements in the KP and LMP health care delivery model.

Figure 7

KP'S HEALTH CARE MODEL	THE LMP'S ROLE
Integrated organizational model including prevention, insurance, and delivery of high quality health care	Integrated, coordinated, partnerships among physicians, managers, and employees
Extensive use of information technology to increase coordination, quality, and efficiency of patient care and services	Implementation of KP HealthConnect systems with attention to retraining and redeployment of workforce and modern principles of work and organizational design
Respect for employees and their representatives	Fair wages, employment standards, and career opportunities; partnership employees and their unions and professional associations
Engagement and involvement of all employees in the delivery of patient and health care services	Workplace partnerships and practices that achieve high quality, efficiency, and patient satisfaction
Membership Growth	Joint marketing of KP products and services
Promotion of High Quality Health Care in America	Joint outreach to the public and policy makers

<u>The KP Health Care Model</u>

An integrated model of health care that includes prevention, insurance, and direct delivery of high quality health care has been KP's defining feature since its inception. More recently, KP has embarked on an ambitious strategy to use new information technologies (under the label of KP HealthConnect) to enhance the flow of information needed to deliver patient care efficiently. Throughout its history, KP has been committed to respecting its employees, their rights to representation, and their need for good jobs and careers. This respect for

employees is critical to engaging the energy, commitment, and talents of all who work at KP in the delivery of high quality, efficient health care and patient services. The current health care crisis and competition from lower cost providers has elevated the need for KP to reach out to current and potential customers and to find ways to serve their needs without undercutting its commitment to high standards of health care. Finally, if KP can deliver on the other elements in this model, it can add value to the debates over how to solve the American health care crisis.

The LMP's Role

For the LMP to be an integral part of the KP health care model and delivery system it needs to serve as an effective integrating and coordinating force across managers, physicians, and employees from the highest levels of the organization to the front lines where services are delivered to patients. It has to demonstrate that by working together and using state of the art principles for integrating new technologies into work processes and systems and attending to the training and workforce adjustments needed to redeploy affected employees, KP HealthConnect can reach its full potential. Moreover, management and physician leaders need to be held accountable for achieving and demonstrating (documenting) the tangible improvements in patient care, economic performance, and workforce satisfaction achieved through implementation of partnership in the facilities and departments where they work. This is why we stress the need to track the effects of Partnership initiatives on these critical outcomes. Program wide initiatives need to have the broad based support and long term staying power to overcome the decentralized features that are so deeply engrained in KP's culture and structures. These are the real tangible results and benefits of the KP model and the LMP that can then be used to market KP's products and services to potential customers and to engage in public policy discussions about how to address the health care crisis in America.

The essence of the shift in emphasis and focus for the LMP we are suggesting here was nicely summed up in the comments of a union representative with a long history of involvement in partnership projects.

> "To move ahead we need stronger sponsorship, and a clear, tight focus on outcomes that matter and that will create motivation. I used to believe that training was the key, but now I've come around to thinking that the key is getting people focused on outcomes that matter, and then that will create motivation and clarify the training people need. The "out of the box" program is all about behaviors and values, not about results. The front line staff at KP care deeply about these outcomes – it's the management and union superstructures that can't keep that focus."

This, in summary, is both the challenge and the opportunity we see for the next phase of the Partnership.