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How Labor-Management Partnerships Improve Patient Care, Cost Control, and Labor Relations: Case Studies of Fletcher Allen Health Care, Kaiser Permanente, and Montefiore Medical Center's Care Management Corporation

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How Labor-Management Partnerships Improve Patient Care, Cost Control, and Labor Relations: Case Studies of Fletcher Allen Health Care, Kaiser Permanente, and Montefiore Medical Center's Care Management Corporation

Abstract
[Excerpt] This paper explores the ways in which healthcare unions and their members are strategically engaging with management through partnership to control costs and improve the patient experience, clinical outcomes, workplace environment, and labor relations. These initiatives depend on making use of the knowledge of front-line healthcare workers, improving communication between all staff members, and increasing transparency. In turn, these initiatives can also lead to more robust and dynamic local unions. Through participating in joint work activities, many union members note feeling more respected in their workplace and more connected to their union. Unions can benefit from these activities by offering their members the ability to inform decisions about how work gets done.

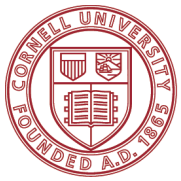
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HOW LABOR-MANAGEMENT PARTNERSHIPS IMPROVE PATIENT CARE, COST CONTROL, AND LABOR RELATIONS

Case Studies of Fletcher Allen Health Care, Kaiser Permanente, and Montefiore Medical Center's Care Management Corporation

Researched and written by Peter Lazes, Maria Figueroa and Liana Katz

February 1, 2012

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EXECUTIVE SUMMARY

In the wake of the Patient Protection and Affordable Care Act signed into law in March of 2010, many healthcare systems are developing innovative ways to improve the quality of the services that they provide while simultaneously controlling costs. However, front-line staff is often excluded from the development and implementation of such initiatives. Yet, the inclusion of front-line staff in quality improvement and cost containment work is crucial because they are often the employees with the most intimate knowledge of where every day work processes break down and viable solutions. Furthermore, to implement change successfully in complex healthcare systems requires commitment and input from all organizational stakeholders. Labor-management partnerships offer healthcare systems a method to engage all staff in productive dialogue to restructure the way care is provided.

The Contact Center at Montefiore Medical Center's Care Management Corporation (CMO, New York City), Fletcher Allen Health Care (Vermont), and Kaiser Permanente's San Rafael and San Diego Medical Centers (California) have all introduced labor-management partnership not only to improve the quality of clinical care and reduce costs but also to create healthier workplaces for staff, strengthen teamwork and improve labor relations. These case studies provide some important data about how healthcare labor-management partnerships are being created and sustained. This report offers only a snapshot of such activities. Further research is still needed to developed complete empirical data on the approaches used and the outcomes that can be achieved.

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

1. **Clinical Processes:** At the Contact Center, Fletcher Allen, San Rafael, and San Diego restructuring clinical processes to be more efficient, patient-centered and cost-effective are

central goals of their partnership work. Clinical process improvements at the four health systems have included advancements such as:

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

2. **Workplace Environment:** An articulated partnership process creates an environment in which front-line staff and management feel comfortable working collaboratively to overcome roadblocks to effective communication, workplace safety and other challenges. This mutual understanding and trust fosters a more respectful workplace and a problem-solving process that includes all voices. Specific outcomes at the four medical centers include:
    - Zero reported workplace related injuries in 2010 and two in the first five months of 2011 (Clinical Laboratory Services, San Rafael).
    - 450 overhead pages per month reduced to 422 total pages per year (Operator Services, San Rafael).
    - Introduction of multidisciplinary rounds (Inpatient Psychiatry, Fletcher Allen).

3. **Labor Relations:** Labor-management partnerships help develop a new paradigm for interactions between management, front-line staff and labor unions that is collaborative rather than adversarial. Representing members at a partnering medical center also provides the union with the opportunity to grow its internal capacity to support partnership activities and deepen member and steward engagement. Improved labor relations are reflected in the following outcomes:
    - Creation of a non-punitive promotional strategy and career ladder (Contact Center, CMO).
    - Nursing staffing ratios developed by nurses and nurse managers (Fletcher Allen).
    - Embrace of partnership as "the way things work" at all levels of organization (Kaiser Permanente, San Rafael and San Diego).

4. **Cost Savings:** An effective labor-management partnership can have a considerable impact on the expenditures of a single unit and the bottom line of an entire healthcare organization. Specific cost-savings that resulted from joint work processes include the following:
    - $51,000 reduction in backfill costs (Operator Services, San Rafael).
    - Reduced staff turnover rate from 14% in 2008 to 3.9% in 2010 (Contact Center, CMO).

- Reduced cost per communication contact from $7.62 in 2004 to $4.06 in 2010 (Contact Center, CMO).
- Reduced nursing staff turnover and traveling nurse hires (Fletcher Allen).

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

1. **Active Union and Management Leadership**: Active union and management leadership ensures that the partnership process has sufficient resources to be successful. Labor and management leadership also need to provide monitoring of partnership activities so that changes are sustained and spread throughout the organization.

2. **Clear Partnership Structure**: A clear partnership structure enables the union and its members to have a direct role in decision-making, quality improvement and work process redesign. A well-defined partnership structure creates a formal process for supporting joint activities.

A common practice is to have a steering committee or council comprised of labor and management representatives responsible for overseeing the partnership activities.

3. **Clear Union and Management Goals**: Both labor and management should develop clearly defined goals for what they hope to achieve through the partnership. These goals should be a combination of union-building, unit-based and hospital-wide.

4. **Institutional Support for Partnership**: Collective bargaining language is usually needed to articulate the goals of the partnership while specifying the roles and responsibilities of those involved in the joint work. Collective bargaining language should be flexible to reflect the changes in the goals and structure of the partnership process as it evolves. In addition, both the union and management need to commit funds for resources such as internal and external consultants, coaches and educators for staff, sufficient time and a budget to provide front-line staff sufficient time to work on partnership activities and to obtain training.

5. **Education**: Union members and managers should be introduced to the structure, purpose and goals of the partnership by union and hospital leaders. These key stakeholders should also understand how providing high quality, patient-centered, and affordable healthcare can be achieved through partnership. Labor-management partnership stakeholders should see their joint work process as an opportunity to restructure the delivery system in which they work and not as a stop-gap measure to allow broken systems to continue to function. Education and training should include innovation methods as well as quality improvement tools.

6. **Communication and Accountability**: Since all staff members do not always have direct ways to participate in partnership activities, there should be active communication between those who actively participate in joint work and those who do not. Tools such as communication trees, communication boards, e-mail and huddles can be used to maintain a flow of information and to obtain input from all staff.

7. **Monitoring and Tracking Results**: Keeping detailed records is critical to analyze and quantify the impact of joint activities. It is also important to share the successes of joint work with peers, patients, varied stakeholders, external partners and regulatory groups in order to illustrate the achievements of the partnership process.

8. **Redesigned Labor Relations**: In order to create an environment that is respectful of the workforce and supportive of a partnership, labor relations need to be conducted in problem-solving rather than adversarial manner.

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

INTRODUCTION

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

> "Unions need to initiate and take the lead to improve the quality of care of patients and find ways to cut costs. Unions can't allow themselves to be bystanders but instead must be champions for these changes."
>
> John August, Executive Director of the Coalition of Kaiser Permanente Unions "Why Unions Should Be Part of the Delivery System Changes," Presentation May 2010.

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

This paper explores the ways in which healthcare unions and their members are strategically engaging with management through partnership to control costs and improve the patient experience, clinical outcomes, workplace environment, and labor relations. These initiatives depend on making use of the knowledge of front-line healthcare workers, improving communication between all staff members, and increasing transparency. In turn, these initiatives can also lead to more robust and dynamic local unions. Through participating in joint work activities, many union members note feeling more respected in their workplace and more connected to their union. Unions can benefit from these activities by offering their members the ability to inform decisions about how work gets done.

Background of Labor-Management Partnerships

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

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

The implementation of partnerships has not been without controversy. Union leaders debate whether labor-management joint work will undermine member support and compromise union autonomy, suggesting an ideological belief that the direction of production and quality improvement falls within the purview of management and not union members. Nevertheless, those unions that have chosen to pursue joint work with management feel that it has and does engender greater respect for workers, increased productivity, increased union density, and improved quality of work life. Rather than compromising the union, labor-management partnerships can in fact expand the influence of the union and its members.

[1] Eileen Appelbaum and Larry W. Hunter, *Union Participation in Strategic Decisions of Corporations* (Chicago: University of Chicago Press, 2004); Thomas A. Kochan and Paul Osterman, *The Mutual Gains Enterprise* (Boston: Harvard Business School Press, 1994); Thomas A. Kochan et. al., *Healing Together* (Ithaca: ILR Press, 2009); Peter Lazes and Tony Costanza, "Xerox Cuts Costs without Layoffs through Union-Management Collaboration." *Labor-Management Cooperation Brief* (July 1984); Saul A. Rubenstein, "The Impact of Co-management on Quality Performance: The Case of the Saturn Corporation," *Industrial and Labor Relations Review* 53, No. 2 (January 2000).

Labor-Management Partnerships in the Healthcare Industry

There have been several significant recent labor-management partnerships in the healthcare industry. As will be discussed in the body of this paper, one of the most longstanding labor-management partnerships in healthcare began at Kaiser Permanente, the largest health maintenance organization (HMO) in the United States. Peter diCicco, on staff at the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), and John Sweeney, past President of Service Employees International Union (SEIU), with a coalition of multiple unions representing Kaiser Permanente employees and Kaiser Permanente management pioneered a comprehensive partnership process in the late 1990s. This labor-management partnership continues to be at the foundation of how Kaiser Permanente operates and meets its organizational goals.

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

Labor-management partnerships in healthcare facilities have required strong and progressive union and management leaders in order to launch and sustain support for joint work activities. Union leaders today have an additional challenge when considering establishing a labor-management partnership. Because union density is declining, union leaders are forced to focus their time and resources in activities that are explicitly "union building."[3] In the context of healthcare in particular, improving quality of care and patient safety and reducing healthcare costs are important goals but not often priorities for senior union leaders. Therefore, in order for labor-management partnerships and quality improvement initiatives to be successful, union

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

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

leaders must make a firm commitment to developing strategies to merge partnership and union-building work.[4]

The Four Case Studies

As was previously stated, this paper is divided into four case studies. The first two case studies investigate San Rafael and San Diego Medical Centers which belong to Kaiser Permanente's healthcare maintenance organization. As with all medical centers at Kaiser Permanente, these hospitals participate in a system-wide Labor-Management Partnership (LMP) which was established in 1997 and involves 11 international unions as stakeholders. The case studies of San Rafael and San Diego focus specifically on the activities of the medical centers' unit-based teams (UBTs), the primary vehicle developed to advance at the unit level the LMP's goal of providing high-quality, cost-effective and patient-centered care in an exceptional work environment. To date, UBT activities, with strong support from both labor and management sponsors, have mobilized the insight and continuous innovation of front-line staff and managers to improve patient care, employee satisfaction, and communication across Kaiser Permanente.

The third case study profiles the Model Unit Process (MUPs) at Fletcher Allen Health Care in Burlington, Vermont. MUPs took root in 2005 after a contract dispute between the hospital and the then newly organized Vermont Federation of Nurse and Health Professionals (VFNHP) regarding nursing staffing ratios. Rather than resolve the issue through arbitration, the union seized upon the opportunity to create a joint process that would not only reconfigure staffing ratios but also tackle improving quality of care, workplace environment and communication. Driven by VFNHP, MUPs has had a significant impact on clinical outcomes, nursing staffing ratios, nurse and nurse manager communication, and nurse engagement at Fletcher Allen. This case study in particular is a testament to the ability of unions to force management and hospital administrators to the table to implement partnership work.

The final case study in this paper details an expansive project at Montefiore Medical Center in the borough of the Bronx, NY. Introduced in 1996, the Care Management Corporation (CMO) was established by the medical center to manage the coordination of comprehensive healthcare services to residents of this impoverished area of New York City. Motivated by a social-justice mission, the CMO has worked to transform an outdated reimbursement system, establish partnerships between with both physicians and community groups, and develop an effective process to manage care for the patients whom it serves. The description of the CMO included in this report will describe the core elements of the CMO's mission and will analyze the joint work underway at the Contact Center (previously known as the Call Center), the CMO department with the most extensive labor-management partnership process.

[4] Union building outcomes includes organizing new members (both internal and external organizing), more contact and engagement with members, greater contributions to political action campaigns, more active stewards, and more activists.

The four healthcare systems profiled have achieved impressive clinical and workplace redesign outcomes through collaborative labor-management partnership processes. However, fostering partnership is not an easy task. For example, at Fletcher Allen nurses and their union spearheaded the partnership initiative but it has proven difficult to disseminate information about and involve all nurses in joint work activities. Furthermore, the collaboration remains largely restricted to nurses and nurse managers. Similar uneven participation is evident within the Kaiser Permanente LMP system: at San Rafael Medical Center, nurses represented by the California Nurses Association (CNA) are largely absent from partnership activities because their union is involved with neither the Coalition of Kaiser Permanente Unions nor the labor-management partnership. On the other hand, at San Diego nurses represented by the United Nurses Associations of California (UNAC) are active participants because their union is a member of the Coalition and has formally agreed to work in partnership. Because of the diversity of partnership processes and experiences at each medical center, these case studies will pinpoint differences and challenges alongside the specific approaches used to achieve results.

Comparative analysis of San Rafael, San Diego, Fletcher Allen and Montefiore's CMO reveals that the involvement of healthcare unions, their leaders and their members in delivery system restructuring initiatives yields concrete clinical improvements as a result of increased involvement of front-line healthcare workers. However, union presence and proactive union leadership is not sufficient to generate the outcomes achieved at the four medical centers discussed in this paper. A clear partnership process coupled with appropriate education, training, and access to information for both staff and management is necessary to provide a venue for front-line staff to participate in sustained problem-solving initiatives, to create a truly collaborative work environment, and to attain substantially improved clinical outcomes. It is this combination of union participation and defined partnership structures that create the context in which substantial improvements in patient care, cost reduction and quality of work life can be achieved.

KAISER PERMANENTE: LABOR-MANAGEMENT PARTNERSHIP

Overview

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

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

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

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

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

[5] Kochan (2009), p.24-5.

[6] Kochan (2009), p.42.

[7] E-mail communication with Tanya Wallace on 1/5/11.

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

LMP infrastructure and activities are funded primarily by the Partnership Trust which collects monies from the 9 cents per hour which is set aside by Coalition union members and funds provided by Kaiser Permanente. The Trust is overseen by six trustees who are also members of the LMP Strategy Group.

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

In order to combat the overall ineffectiveness of partnership activities in these areas, the 2005 National Agreement set forth "appropriate structures and processes for Partnership interaction to take place" that would involve front-line staff and management in on-going collaboration at the department level.[8] These structures and processes would come to be embodied in the Unit-Based Team (UBT). The following sections will detail the genesis, general structure and goals of UBTs across Kaiser Permanente. In addition, it will chart the progress, outcomes and challenges of UBT activities at two different Kaiser Permanente facilities: San Rafael Medical Center in Northern California and San Diego Medical Center in Southern California. These descriptions will highlight the involvement of unions in sustaining UBT work and will pay special attention to providing specific examples of how UBTs have impacted clinical outcomes and front-line staff engagement at the two medical centers.

Structure and Goals of Unit-Based Teams across Kaiser Permanente

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

[8] See Appendix A for collective bargaining language from the 2005 and 2010 National Agreements regarding unit-based work.

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

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

Kaiser Permanente Value Compass



[10]

[9] Kochan (2009), p.192.

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

As was mentioned above, UBTs are designed to involve every member of a "natural work unit" or department. In large departments or departments that exist at multiple facilities within one medical center, UBTs may use a representative model where staff members from each shift or from each facility are chosen by their peers with guidance from union representatives to serve on a UBT representative group. The representative group reports back pertinent information to all staff members who, while not in the representative group, are still members of the UBT. For example, at San Rafael Medical Center in Northern California the Clinical Laboratory department consists of fifty employees at the medical center's main location and three satellite clinics. Therefore, the UBT representative group includes members from each position and from each shift (clinical lab scientists, lab assistants, clerical employees, night shift, day shift and satellite clinics). For an illustrative counterexample also from San Rafael, the Operator Services department is comprised of only 13 employees. The small number of staff members makes it possible for the department to operate without a representative group. Regardless of unit size, all staff members participate in UBT activities and have a responsibility to support partnership principles, complete trainings, express their ideas, communicate respectfully with each other and their co-leads, participate in decision making and implement agreements.11

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

Each UBT also has dedicated labor and management sponsors who provide support for the teams and accountability for their work. Management sponsors, who are usually department heads, have specific responsibilities: supporting the partnership, keeping the UBT visible, supporting UBT success, authorizing and advocating for change, allocating resources for success and "walking the talk" or, in other words, enacting the principles of the partnership in their

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

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

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

managerial duties.14 They have authority for allocating budgetary funds for UBT projects and initiatives.

Like management sponsors, union representative sponsors have a unique role in fostering the growth of UBTs. "Sponsorship is key. It is critical," says José Simoes, the Director of the Service Employees International Union-United Healthcare Workers West (SEIU-UHW) Kaiser Permanente Division, because union representatives serve as mentors for both newly formed teams and high-performing teams.[15] They help staff members understand the divisions between partnership work and collective bargaining and give successful teams suggestions for how to sustain engagement. Furthermore, the presence of union sponsors demonstrates strong union support for UBT activities. Bill Robotka, a Union Representative and Clinical Laboratory Services UBT sponsor from Engineers and Scientists of California-International Federation of Professional and Technical Engineers (ESC-IFPTE) Local 20 sees himself as a "friendly uncle" who occasionally contributes ideas at UBT meetings but largely serves to equalize the balance of power with management.[16]

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

While the training for UBT members is a product of Kaiser Permanente's LMP, the teams are largely responsible for setting their own goals based on the strategic goals of their region and

[14] Ibid.

[15] Interview with José Simoes on 6/28/11.

[16] Interview with Bill Robotka on 2/23/11.

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

tracking the results of their improvement projects.[18] "Early in the team's development, UBTs identify performance indicators that reflect business and job satisfaction, are meaningful to their unit and support national, regional and local goals."[19] UBT co-leads record their projects and performance progress by entering data into the UBT Tracker which is an online tool introduced in 2009 that monitors projects and data by unit, facility and region. The UBT Tracker also records each UBT's performance evaluation which is measured on a scale from one to five and is based on Path to Performance Criteria.[20] The five point scale is comprised of the following gradations: 1. Pre-team climate, 2. Foundational, 3. Transitional, 4. Operational, and 5. High-Performing. The Path to Performance evaluates UBTs in the following areas: sponsorship, leadership, training, team process, team member engagement, use of tools, and goals and performance.

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

As of November 1, 2011, 880 teams (26 percent) of UBTs are at a level 1 (Pre-Team Climate) and 142 teams (4 percent) are at a level 5 (High Performing) according to Path to Performance metrics. Kaiser Permanente and the Coalition of Kaiser Permanente Unions face the challenge not only of attaining the increase in high-performing teams set forth above but also, as teams move up through the Path to Performance rankings, developing a strategy for supporting and deepening the activities of teams that have already reached a high level of performance.[21]

Labor-Management Partnership Activities at San Rafael Medical Center

Overview

San Rafael Medical Center was established in 1976 and is one of the two medical centers in the Marin Sonoma Service Area of the Northern California Division of Kaiser Permanente. It

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

[19] Kaiser Permanente Labor Management Partnership, http://www.lmpartnership.org/ubt/track-performance.

[20] See Appendix A for the Path to Performance evaluation criteria.

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

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

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

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

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

UBT Structure and Process

The majority of the UBTs at San Rafael encompass the entire department. However, there are some larger departments that exist across San Rafael's three inpatient and outpatient facilities that utilize the representative model. For these teams, participants are chosen on a voluntary and

[22] Interview with Patricia Kendall on 3/16/11.

[23] Interview with Eileen Kilgariff on 2/10/11.

[24] Interview with Joan Mah on 6/6/11.

elected basis. According to Joan Mah, representative group members are charged with ensuring that there is "two way communication" between all members of the department. Team member roles and responsibilities conform to the general model described in the previous section.

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

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

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

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

Clinical Laboratory Services (CLS), Projects and Outcomes

[25] Interview with Patricia Kendall on 3/16/11.

[26] Interview with Joan Mah on 6/6/11.

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

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

The CLS UBT is also remarkably open to collaborating with and learning from other departments and Kaiser Permanente facilities. Ramona Guiles, a former UBT co-leader, recounts traveling to another facility to examine what chairs were being used successfully in their drawing station and being able to get those same chairs for San Rafael.[27] The department has also created a workplace safety team to identify and address the safety concerns of all staff. This team has opened up its meetings to and shared its charter with other departments that are struggling with workplace safety issues. The CLS department had zero reported workplace related injuries in 2010 and two in the first five months of 2011.

Workplace Related Injuries and the Bottom Line

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

Unsafe work environments which lead to injuries directly impact the bottom line of healthcare organizations which must not only compensate the injured employee but also must face expenses related to hiring temporary replacement staff, lowered morale and efficiency of other staff, and replace any damaged equipment. It has been estimated that these indirect costs can amount to 3 or 4 times the direct costs

Workplace injuries can be avoided by growing a culture of safety among front-line staff in which they feel comfortable discussing safe work practices with their peers and are actively involved in securing appropriate equipment and developing safety protocols.

[27] Interview with Ramona Guiles on 2/28/11.

The most significant CLS UBT initiative to date was the remodeling of the laboratories at San Rafael and at the clinic in Novato. This project began in October of 2008 and was completed in 2009. The UBT was intimately involved with all aspects of the remodeling process, approving and making changes to blueprints and subsequently monitoring the success of the remodel. The UBT was actively vigilant and was able to addresses workplace safety issues that arose during the redesign process. For example, the old laboratory flooring consisted of concrete and linoleum and resulted in considerable workplace injuries. To correct this problem, the department purchased anti-fatigue mats. These mats only caused more injuries and the UBT was enlisted to research alternative flooring options to reduce workplace injuries.

In addition to active involvement in the remodeling of San Rafael laboratories, the CLS UBT also focused its energy on engaging with the medical center's initiative to become a stroke center of excellence in 2009. The CLS department was failing to meet the suggested 45 minute Turnaround Time (TAT) for stroke alert patients' tests. The team analyzed the process of the department's approach to running tests to understand why they were failing to meet the appropriate TAT. Using "mock stroke alerts" during which the department would receive drawn blood samples from the Lab Assistant in the Emergency Department, perform the necessary tests and report the results, the CLS UBT came up with a detailed understanding of their process and an extensive list of ways in which they could improve their TAT. Solutions included basic changes such as insuring that the CLS department supervisor checked to make sure that a Lab Assistant has accepted the assignment to draw blood samples from the stroke alert patient and using a timer to encourage CLS Chemistry staff to remove samples from the centrifuge in a prompt manner. Other solutions involved on-going reflection and discussion of the department's response to stroke alert patients by recording all stroke alert cases in a notebook which allows for easy troubleshooting. The UBT currently tracks the department's TAT and the team is generally able to achieve the 45 minute benchmark TAT.

Finally, as was mentioned above, the CLS UBT has been actively involved in improving workplace safety and staff communication since its inception in 2007. Because the CLS department is open 24 hours a day, 7 days a week and is present at four different facilities, the UBT found that department meetings only effectively reached 55 percent of staff members. Even scheduling 2-4 meetings per month failed to increase the amount of staff present at meetings and staff awareness of the issues discussed. In 2008 the UBT learned that other departments within San Rafael were successfully implementing huddles to improve staff communication and dissemination of information and decided to do the same in the CLS department. Currently the CLS department has brief huddles at the turnover between the day and evening shifts to discuss safety issues, to read department safety rules, technical issues and supply issues. These huddles are initiated by shift supervisors, shop stewards or department managers. The CLS UBT aimed to have 20 huddles per month and in July of 2011 the department surpassed that goal, conducting 28 huddles in the month.

These projects developed by the CLS UBT demonstrate the wide array of departmental functions that a UBT can be actively involved in tracking and improving. From streamlining clinical procedures to promoting workplace safety, the CLS UBT has harnessed the insight of its staff members to transform a department that felt neglected into a safe and efficient department designed by its staff, for its staff.

Obstetrics and Gynecology (OB-GYN), Projects and Outcomes

The OB-GYN Department consists of 26 staff members and its UBT utilizes the representative group model. The team was established in 2009 and currently meets once a month. According to Eileen Kilgariff (RN Manager), the partnership is actively involved in all changes that are made in the department.[28]

In 2011, the OB-GYN UBT decided to undertake a series of projects to improve staff interaction with patients and accessibility to care services for patients. With this goal in mind, the team worked to decrease the number of patient education materials distributed in hard copies by encouraging OB-GYN patients to sign up for Kaiser Permanente's on-line information services. In addition, the team revised their on-line homepage to be more easily navigable by patients. Through these efforts, the team was able to decrease the number of education materials distributed to patients by 60%. The decreased number of patient education materials distributed and an improved web presence also allowed the department to cut costs and to reduce their environmental impact by limiting their dependence on paper goods.

"Going Green" in Healthcare

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

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

The UBT's earlier projects focused on improving attendance and employee wellness by promoting exercise and healthy diet. To this end, the UBT launched the "Biggest Department" challenge which took the lunch hour to introduce staff to

[28] Interview with Eileen Kilgariff on 2/10/11.

healthy diets and to stress reduction techniques. Attendance remains a difficult sticking point for the team as its various efforts have not lead to significant improvements. "We tried contest between facilities, drawings for prizes, shame and recognition without any measurable changes," notes Eileen Kilgariff.[29] In 2011, the team hopes to cut down one missed day per facility but it is unclear if and how they will be able to reach this goal.

The OB-GYN UBT also still struggles to communicate effectively with unit staff members. The lack of information for staff about partnership work and UBT projects can cause resentment about the amount of energy that is devoted to UBT initiatives. Nevertheless, the team has been able to raise staff awareness about health and patient courtesy considerably since the institution of UBT work and change continues to permeate the unit slowly but surely.

Operator Services, Projects and Outcomes

The Operator Services UBT includes all 13 department staff members and two managers and conducts monthly meetings. The UBT initially concentrated on improving collaborative decision-making and ultimately progressed to tackling more specific unit problems. The team's current focus rests on examining issues of budgeting, safety and attendance.

> "In 2009 we went from 450 overhead pages per month down to 422 pages for the entire year. That is very significant."
>
> Bev Cleland, Manager and UBT Sponsor, Operator Services

Beginning in 2009, the UBT began a series of projects to help improve patient satisfaction and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.[30] The team decided that the most effective way to improve both of these scores would be to decrease the number of overhead pages in the hospital, leading to higher patient satisfaction due to a quieter hospital stay and allowing the operators to answer more member calls instead of making overhead announcements. Before the UBT decided to address the issue of excessive and noisy overhead paging, Operator Services department staff members would often use overhead paging to get in touch with staff members because it was the easiest mode of communication. "We used to announce meetings and special events overhead. This also created a lot of overhead noise for the inpatients and noise in our integrated facility in

[29] Interview with Eileen Kilgariff on 2/10/11.

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

general," notes Bev Cleland (Manager and UBT Sponsor, Operator Services).[31] The UBT team proposed to eliminate all overhead pages except for medical codes, a solution which was approved by San Rafael's executive administration and implemented throughout the medical center. "In 2009 we went from 450 overhead pages per month down to 422 pages for the entire year. That is very significant," says Cleland.[32]

In 2010, the UBT undertook a second project to improve service known as the Service Recovery Project which harnessed the skills and knowledge of the operators in order to give Kaiser Permanente members better access to all departments at San Rafael. Because the operators cannot afford to dedicate large amounts of time to resolving department issues that create barriers to access, the UBT designed a simple, four question protocol that would help quickly transfer the member to the manager of the inaccessible department. The UBT collected suggestions from department staff members about what kinds of calls they receive most and what questions would be most essential for establishing the protocol. "Because they live it, they know what is needed on the sheet," says Amy Mahoney (Management Co-Lead, Operator Services).[33] Ultimately, the UBT devised a protocol that consisted of asking the member for their name and medical record number, whether they had a telephone appointment, whether they received a call back, and whether they could not access the necessary department. Following these questions, the operator would apologize to the member and inform them that they would be transferred live to the manager of the pertinent department. Bev Cleland, Operator Services supervisor and UBT sponsor, then presented the idea to San Rafael's Clinical Administration and, subsequently, to the medical center's managers meeting. Managers were eager to learn how they could improve work processes in their own department from the perspective of a Kaiser Permanente member and approved the implementation of the project.

A final initiative that was developed by the Operator Services UBT was designed to help the department save money without reducing quality of service. The team identified that they could survive on certain low call volume call days without backfilling for vacation or sick leave. By making these reductions in staffing levels, the department was able to save $51,000 in 2010. Quality of service did not suffer and San Rafael ended the year with the least amount of abandoned calls in the Northern California region.

The projects developed by the Operator Services UBT are a powerful illustration of the ability of UBT work to impact not only patient satisfaction as aligned with Kaiser Permanente's value

[31] Unfortunately the hospital's HCAHPS score remained the same due to a renovation project which contributed to the noise level at the hospital. Interview with Bev Cleland on 3/15/11.

[32] Ibid.

[33] Interview with Amy Mahoney on 3/8/11.

compass mentioned in a previous section but also cost savings, workflow efficiency, staff engagement and inter-departmental collaboration.

Medical Center-Wide Outcomes

As Tony Fiorello notes (CNO and COO, San Rafael), UBTs have provided a local venue for the goals of the partnership to be disseminated and a common framework for problem-solving.[34] Furthermore, the problem-solving process itself has been improved with the addition of front-line staff. "It makes a huge difference when you have front-line staff involved," says Ramona Guiles (former CLS UBT labor co-lead) because they have intimate knowledge of work processes and creative solutions for how to streamline those processes.[35] Guiles also notes that not only are front-line staff included in the problem-solving process but also they are becoming increasingly vocal about their needs and problems that they see arise on their units. She remarks that nobody is afraid to say, "We need to change this" because the UBT provides a space in which concerns can be heard and addressed.

In addition to frontline staff inclusion in problem-solving activities, UBT work has also helped to foster increased transparency at San Rafael. Staff now has access to their department's budget and to their manager's salaries. When staff proposes a project they review the department budget with managers to test the initiative's financial viability. In addition, staff has access to the same training classes as managers which includes business literacy courses. This has "leveled the playing field," comments Denise Senior (UHW Representative Chair).[36]

Finally, UBT work has encouraged a greater openness and willingness to change for both staff and management. There is a collegiality between labor and management that extends to the physicians notes Patricia Kendall (Medical Group Administrator, San Rafael).[37]

Impact of and on the Union

Through their involvement in UBT work UHW and ESC Local 20 have become more engaged in discussions concerning remodeling and have taken an active interest in learning more about what staff members need in terms of technology. The unions have become increasingly concerned with identifying what staff needs to keep their licenses and are offering classes to help their members advance within Kaiser Permanente. According to Bill Robotka, UBTs have allowed the unions to become much more engaged at Kaiser Permanente than at any other healthcare

[34] Interview with Tony Fiorello on 3/28/11.

[35] Interview with Ramona Guiles on 2/28/11.

[36] Interview with Denise Senior on 3/28/11.

[37] Interview with Patricia Kendall on 3/16/11.

organization, shifting the focus of labor relations away from adversarial conflict resolution to building relationships between staff and management.[38]

José Simoes notes that UBT work has also provided the opportunity for UHW in particular to think about union-building activities in a new way and to build the capacity of the union to work with and support partnership activities.[39] UHW, alongside the other unions in the Coalition of Kaiser Permanente Unions, were initially involved in UBT work at the most basic level: negotiating UBTs into the National Agreement in order to ensure that labor-management partnership would form the operational framework of Kaiser Permanente. Now that UBTs have been implemented widely across the organization and continue to thrive, UHW is experimenting with how best to mentor its members to work effectively within the partnership environment. Simoes argues that participation in partnership activities benefits the union and its members because partnership gives front-line staff a real voice in the workplace. This, he believes, has a larger positive impact than the contract that the union negotiates with Kaiser Permanente.

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

Current Challenges

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

1. **Lack of nurse involvement:** A barrier to the success of UBT activities as San Rafael stems from the fact that CNA nurses are not officially involved in unit-based teamwork due to the ideological approach to labor relations adopted by the CNA, the union that represents nurses at San Rafael. Since nurses are significant players at the unit level, their lack of participation in UBTs can create tension between nurses, other healthcare professionals and management. As Tony Fiorello notes, not having the nurses involved in UBT activities reduces the effectiveness of problem-solving activities, communication, and department efficiency.[40] Furthermore, the absence of an important stakeholder from the partnership process diminishes the scope of impact that UBTs can have on

[38] Interview with Bill Robotka on 2/23/11.

[39] Interview with José Simoes on 6/28/11.

[40] Interview with Tony Fiorello on 3/28/11.

restructuring clinical processes and workplace environment.

2. **Staff engagement and communication**: One of the most significant current challenges to UBT work at San Rafael is engendering support and enthusiasm for UBT activities from all staff members on each unit. This challenge results from a root problem of communication, which is not always frequent or clear, between UBT representative groups and unit staff. When communication breaks down it is difficult for staff to understand the purpose of projects, the broader goals of the UBTs and, therefore, the value of partnership work. When staff sees the impact that UBTs can have at the unit level, they become more supportive of UBT activities.

3. **Supportive management/union sponsors and the limited reach of partnership:** Just as it can be difficult to elicit total staff support for UBT activities in any given department, it can be challenging when a manager is perceived to be unsupportive of UBT activities. Some staff members and participants in UBT work note that some managers have in some cases continued to make decisions outside of the partnership without consulting the staff. Similarly, there is a perception among some management that the union will protect an employee that is low-performing to the detriment of quality improvement initiatives at the hospital level. Similar comments can be made concerning the fact that union representatives do not consistently sponsor UBTs and that union leadership can be as equally resistant to change as management.

4. **Scheduling challenges**: Because there are multiple competing interests for staff and management's time at San Rafael, meetings for the UBT, for the department and for other initiatives can consume a significant portion of an employee's day. Some departments have addressed this challenge by replacing their department meetings with a daily huddle that lasts only ten or twenty minutes. However, developing methods to effectively and efficiently work on UBT projects and communicate the process to all stakeholders can still prove difficult.

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

Overview

The San Diego Medical Center Area is the third largest service area in Kaiser Permanente with 508,000 patient members living in the surrounding community which can be characterized as diverse both in terms of ethnic backgrounds and income levels. This service area is comprised of one medical center, 22 outpatient clinics and a Home Health Care division which employs more than 7,400 staff members and 1,100 physicians.

The unions representing employees in the San Diego service area include the following: Office and Professional Employees International Union (OPEIU) Local 30 which represents the technical and professional staff, service and maintenance workers and clerical employees;

United Nurses Associations of California-American Federation of State County and Municipal Employees (UNAC-AFSCME) which represents RNs and nurse practitioners and other nursing job classifications; the United Food and Commercial Workers (UFCW) Local 135 which represents pharmacy technicians and clinical scientists; and the Kaiser Permanente Nurse Anesthetist Association (KPNAA), representing certified registered nurse anesthetists. Psychologists and social workers are represented by the National Union of Healthcare Workers (NUHW) which is not part of the labor-management partnership. Unlike at San Rafael Medical Center where nurses are represented by the CNA, the nurses represented by UNAC at San Diego are formally part of the labor-management partnership.

The initial vehicle for partnership in the San Diego service area consisted of a LMP Steering Committee which included leadership from all partnering unions as well as from the Kaiser Medical Group and the Kaiser Hospitals and Health Plan. During this start-up period, much of the partnership activities focused on getting "the LMP Steering Committed established and functional," said Kaiser Permanente LMP Consultant Sylvia Wallace.[41] There were some project-based teams engaged in workplace safety activities but the partnership did not widely reach frontline workers and was mostly limited to the higher ranking labor and management leadership in the area.

After unit based teams were established by the 2005 National Agreement between Kaiser Permanente and the Coalition of Kaiser Permanente Unions, Wallace states that the San Diego Area Steering Committee devoted time to assessing "what needed to be done to help the UBTs get started, trained, and focused on improvement of performance" in the following areas: attendance, clinical quality, inpatient and outpatient service, workplace safety, and workforce health. At this time, adds Wallace, "there were day-long mandatory LMP training classes for employees, covering basics such as LMP orientation, consensus decision making, working in a partnership environment," and other subjects.[42] When first established, these classes used regional program curricula. They were later streamlined and customized to fit the San Diego area and were eventually adjusted to be delivered at UBT meetings.

In the spring of 2007 the San Diego service area rolled out its first 9 pilot Targeted Unit Based Teams (T-UBTs), including the 4North/South Postpartum and the Intensive Care Unit/Critical Care Unit at the San Diego Medical Center, clinical laboratory units in multiple locations, and the Operating Room at Otay Mesa. As of November 1, 2011, there are 133 teams in place. With the exception of approximately eight departments, all units and facilities in the San Diego area have a UBT. Of the 133 teams, 5 are functioning at Level 1 according to the Path to Performance evaluation rubric, 11 at Level 2, 35 at Level 3, and 82 at Level 4.[43] In fact, San Diego has been

[41] E-mail communication and interview with Sylvia Wallace on 8/9/11 and 8/12/11.

[42] E-mail communication and interview with Sylvia Wallace on 8/9/11 and 8/12/11.

[43] See Appendix A for Path to Performance evaluation information.

featured as one of the "brightest stars in the UBT constellation" by the Kaiser LMP.[44] Key factors contributing to the success of the partnership in the area have been the highly effective resource team comprised of UBT and LMP consultants as well as the active involvement and support of the service area UBT labor and management sponsors (OPEIU Local 30's President and San Diego Medical Center's Assistant Administrator).

UBT Structure and Process

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

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

The UBT Implementation Team coordinates and supports the work of all UBTs in the San Diego service area. This team has a labor co-lead (the President of OPEIU Local 30), a management co-lead (the Assistant Administrator of San Diego Medical Center), a Lead UBT Consultant, and about 4 LMP or UBT consultants. According to Lead Consultant Jenny Button, consultants at San Diego attend all UBT meetings to provide ongoing coaching and mentoring. These consultants also facilitate the training required for representative group members. In addition to the training mentioned above, partnership training in the San Diego area includes Sponsor training, RIM+ (rapid improvement model) for co-leads, Performance Academy advanced training for co-leads, and other specialized classes such as business literacy, focused learning, and use of the UBT Tracker. Such training is necessary for the UBTs to advance toward becoming self-sustaining performance improvement teams.

[44] "The San Diego UBT fair: Sharing successful practices," Kaiser Permanente Labor Management Partnership, http://www.lmpartnership.org/.

As in other service areas, UBTs in San Diego are the vehicle for achieving performance improvements and have facility-wide and department-specific goals. While department-specific goals necessarily vary by unit, global goals include improving the following: attendance, clinical quality, healthy workforce, service quality (outpatient and inpatient care), workplace safety, access, patient safety, affordability, and employee engagement. To monitor progress in achieving these goals, the San Diego Implementation Team has employed evaluation mechanisms and metrics that are used throughout the Kaiser LMP as well as tools that were developed locally in the San Diego area. The unique measurement tools and performance improvement indicators in the San Diego service area include the following: 1. The UBT Statit Scorecard is a web-based system which provides teams with regular access to their metrics "all in one place." It includes a set of standard metrics such as attendance, quality (clinical goals), service (outpatient care experience), workplace safety, workforce and affordability. UBTs can also customize the system to track variables specific to their own work. 2. The San Diego UBT Status Report is a local Excel-based worksheet which provides more detail than the UBT Tracker. It contains notes and recommendations specific to each team as well as team meeting times and team ratings among other variables.

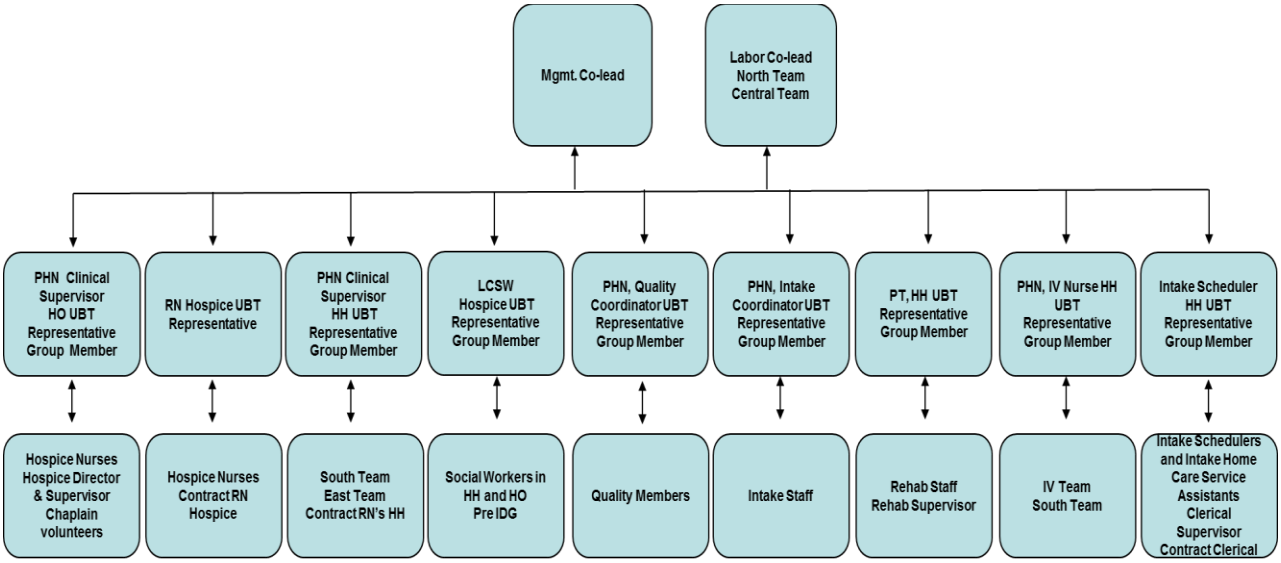
Other important factors influencing the effectiveness of UBT work across the service area are the implementation of communication systems within and between teams as well as mechanisms to diffuse best practices. Systems for communication within teams primarily include communication trees, bulletin boards, email and daily huddles of 5 to 10 minutes, as well as monthly meeting of the representative group. Systems for communication between teams involve the use of newsletters and quarterly meetings of co-leads from all teams that are held to exchange information and provide feedback on each other's work. Communication systems between teams also serve as means to share best practices. UBT fairs are also another way in which best practices are shared amongst teams in the San Diego area. At these fairs, UBTs display storyboards about their teams' goals and recent outcomes.[45]

As can be seen in the chart on the following page, communication trees mirror the structure of the UBTs such that each representative group member is responsible for communicating with a sub-group within the UBT.[46] This tool promotes one-on-one communication among all UBT members, thereby ensuring that UBT goals and processes are spread effectively throughout the unit or department. In summary, the key elements of the successful implementation of UBT and partnership work in the San Diego Service Area have included the strong commitment of the area's union and management leadership, highly effective consultants, workforce engagement through the teams' structure and participatory processes as well as communication tools.

[45] Other areas that have hosted UBT fairs include Hawaii and Orange County. "The San Diego UBT fair: Sharing successful practices," Kaiser Permanente Labor Management Partnership, http://www.lmpartnership.org/.

[46] See Appendix A.

Communication Tree: Home Health Care UBT



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

Home Health Care, Projects and Outcomes

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

In late 2009, the UBT began working on a project to improve the department's response time so that more home care patients could receive care in a timelier manner. The team identified a problem of backlog due to long and unmanageable discharge lists which resulted in only 44 percent of patients seen within the requisite 24-hour window following discharge from the hospital or referral from a physician. To tackle this problem, the team undertook Rapid Improvement Model (RIM+) training, created specific goals to increase the percent of patients seen within 24 hours, and developed process flow maps between December 2009 and January 2010.

Following the aforementioned work, the team was able to implement two changes to the unit's work process to improve response time. The first change involved streamlining the processing of the referral list, a practice previously implemented at Kaiser Permanente's Riverside Medical Center. This list is the queue of patients who are referred by a physician to home health care and it could include 50 or more names on any given day. Under the old system, intake nurses would examine the daily list and ask a department clerk to process a referral. This process involved several information exchanges between nurse and clerk to verify accuracy of the information,

resulting in duplicate work and considerable time (often days) before a nurse would finally contact the patient. Using the new process, clerk involvement and middle steps were eliminated so that nurses could process the referral themselves.

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

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

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

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

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

2 North/2 South Medical Surgical Unit, Projects and Outcomes

The 2 North/2 South UBT was formed in October of 2008. The unit includes approximately 100 employees and 224 beds. The UBT possesses a representative group of 11 members which

includes a management co-lead and two labor co-leads, both of whom are RNs and members of UNAC.[47]

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

The team began by providing safety observation training for all staff which was previously available only for charge nurses and managers. With this training, each staff member was then required to conduct three safety observations per week. Staff focused their observations on the department's "turn teams" which are responsible for turning patients every two hours in an effort to prevent pressure ulcers. Many staff injuries occur during this process. With all staff conducting safety observations, the number of observations increased dramatically from the 24 observations per month conducted by managers to 500 observations per month. "The frequency of the observations kept proper patient-handling techniques at the forefront of team members' minds," notes Jenny Button, Lead UBT Consultant at San Diego.[48]

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

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

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

[48] Interview with Jenny Button on 4/8/11.

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

Emergency Department, Projects and Outcomes

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

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

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

Medical Center-Wide Outcomes

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

called the Performance Sharing Program (PSP). PSP offers a cash payout that supplements the regular pay of union employees who are in the partnership when the annual performance goals established by the regional LMP council are met or exceeded.[49] Under this program the following variables are monitored: attendance, clinical goals, healthy workforce, inpatient care experience, outpatient care experience, and workplace safety. For most of these variables during the first four months of 2011, the San Diego medical center area was on track to reach and exceed the 2010 year performance scores. For example, in terms of attendance, the 2010 year-end mark for "last minute" sick absences was an average of 3.89 days. For 2011, the minimum target is to reduce last minute sick absences to 4 days (an average of all medical center area employees) and the maximum target is to reduce them to 3 days. As of April 2011, San Diego area's performance was at 3.77 days, exceeding the minimum target of 4 days.

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

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

Impact of and on the Union

An important factor for the success of the partnership in the San Diego medical center area has been the ability of both labor and management to learn to work together and, as expressed by Ray Hahn, to achieve stable labor relations and positive work environment. According to Hahn, the San Diego service area operates in "an

> *"The Union is there for the members. Not just for disciplinary issues, but to educate and provide them with opportunities to have a voice at work."*
>
> *Marianne Giordano, San Diego LMP co-Lead. Interview on 5/5/11.*

[49] Bonuses are based on the region's overall financial performance and the medical center area's attainment of the PSP (Performance Sharing Program) goals.

environment that fosters collaboration and partnership between labor and management. This is really the foundation of how we work."[50] Getting to this level require considerable effort from both labor and management. Unions played an operative role in advising management about how to work in partnership and maintaining the integrity of the collective bargaining agreement, according to LMP co-lead Marianne Giordano.[51] The training programs and tools mentioned above were also essential for building the partnership as were the incentive payout programs. Through these mechanisms, union employees not only gained material benefits but were empowered to influence the way in which work was organized and performed.

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

Current Challenges

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

1. **Sustaining improvements:** UBT members have identified the need to develop mechanisms to sustain the improvements achieved through their work. The existing tracking systems show that there is fluctuation in the results obtained for the multiple variables currently monitored. One factor contributing to the fluctuation in results is the uneven strength of the teams in their capacity to implement partnership work. "Some UBTs have strong representative groups and some perform better than others," says a union representative. Another factor derives from the nature of the work which involves a high level of intensity and time pressures which make it difficult for teams to stay focused on specific variables.

2. **Operating in crisis mode:** Despite the long-term global goals set for the UBTs and the support provided to achieve them, there is a persistent tendency to focus on the crisis of the day that needs to be addressed immediately, according to Lead Consultant Jenny Button.[52] As mentioned above, this tendency might not only work against sustaining improvements but also stifle the expansion of the partnership as less time and fewer resources are devoted to partnership activities to address more urgent issues.

[50] Interview with Ray Hahn on 3/30/11.

[51] Interview with Marianne Giordano on 5/5/11.

[52] Interview with Jenny Button on 4/8/11.

3. **Union sponsorship:** It has been challenging for the partnership in San Diego to enlist union sponsors for the UBTs. Currently, most of the UBT sponsors are from management and only a limited number from unions due to the fact that union staff members feel that it is difficult to leave their work duties and make time for LMP activities. Medical centers in other service areas have addressed this challenge by establishing a pool of labor sponsors who can serve the UBTs on an ad-hoc basis.[53] The San Diego area might benefit from the adoption of a similar system.

4. **Staff engagement and communication:** Although great progress has been made in terms of developing communication mechanisms such as communication trees, huddles, and email, due to the size of the medical center area, the partnership in San Diego faces difficulties in reaching all staff members and keeping them informed about and engaged in partnership work. This is particularly the case in the largest departments and units. The aforementioned challenges of insufficient union resources and the persistent crisis mode contribute to exacerbating the difficulties in educating and mobilizing the staff around partnership goals and activities.

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

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

On a more local level, UBT activities have allowed for interdepartmental sharing and diffusion of ideas that have contributed to the improvement of hospital and regional-wide functioning. As activities at San Rafael and San Diego illustrate, co-leads have ample opportunity to visit other facilities to learn about best practices and to institute those practices at their home facility. In addition, UBTs share their projects internally through the use of the UBT tracker which is accessible by all other teams operating within the same region, through monthly co-lead meetings and the active sharing of team activities by the senior UBT consultants at each facility.

[53] "Taking a dip into the labor sponsor pool," Kaiser Permanente Labor Management Partnership, http://www.lmpartnership.org/.

The local autonomy given to medical centers to develop unique approaches to solving problems and structuring partnership relationships has had a positive impact in terms of the spread of best practices but also has created considerable inconsistency across medical centers. As José Simoes notes, this means that the success of UBT initiatives often depends upon local conditions. Nevertheless, this provides the unions involved with the opportunity to determine how they can best help high-functioning UBTs and medical centers export their processes to other sites.[54]

Alongside encouraging unions to become a conduit for the diffusion of best practices, the LMP process and the Coalition of Kaiser Permanente Unions has encouraged the unions to think of building their internal capacity in a nontraditional way. Current partnership work has helped the unions evolve alongside management to be able to function effectively in a partnering environment. "The more you invest in [UBT work], the less you have to do on a traditional union level," José Simoes. There have been challenges, of course, along the way but "you cannot argue with the results," says Simoes.[55]

FLETCHER ALLEN HEALTH CARE: MODEL UNIT PROCESS

Overview

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

The establishment of Model Unit Process (MUP) activities at Fletcher Allen in 2006 is inextricably tied to the creation of the Vermont Federation of Nurses and Health Professionals (VFNHP) Local 5221, a local union comprised of LPNs and RNs affiliated with American Federation of Teachers (AFT). When VFNHP, which is currently the only labor union present at Fletcher Allen, came into existence as a bargaining unit in 2003, the nurses it represented were largely concerned with securing appropriate staffing ratios for the hospital. Article 20 in the first contract between VFNHP and Fletcher Allen signed in 2003 stated that both the union and the hospital agreed that "staffing the Hospital with the appropriate number of skilled, reliable

[54] Interview with José Simoes on 6/28/11.

[55] Ibid.

nursing employees is an essential element for the provision of quality patient care."[56] To ensure that nurses were adequately staffed, the contract established the creation of a Staffing Committee comprised of three bargaining unit employees chosen by the union and three nursing administrators chosen by Fletcher Allen. This team would develop a staffing budget and plan "consistent with staffing ratios approved by national nursing specialty groups as well as findings from national nursing research regarding nurse staffing and patient outcomes."[57]

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

MUP activities have enabled nurses to become involved not only in determining appropriate staffing levels but also in influencing the way in which units function at Fletcher Allen through the redesign of care delivery and work processes. MUPs were formally written into the 2009-2011 collective bargaining agreement between VFNHP and Fletcher Allen "with the intent of creating a collaborative culture, reducing financial impact and building a systems-wide approach to quality improvement."[58]

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

Structure and Goals of the Model Unit Process

The inspiration for MUPs originated in a visit that Jennifer Henry, past president of VFNHP Local 5221, made to Sunnyside Medical Center, a Kaiser Permanente facility in Clackamas, Oregon in late 2005 before the staffing ratio arbitration was resolved. Energized by the

[56] Article 20, 2003-2006 VFNHP and Fletcher Allen Health Care collective bargaining agreement.

[57] Ibid.

[58] Article 20B, 2009-2011 VFNHP and Fletcher Allen Health Care collective bargaining agreement.

partnership work that was taking place at Sunnyside as part of the system-wide Labor-Management Partnership at Kaiser Permanente described earlier, Henry returned to Fletcher Allen inspired to institute a similar joint labor-management process at Fletcher Allen. Henry envisioned that such an initiative would bring about a "culture change" more than could be done by having an arbitrator determine staffing ratios.[59] For Henry, labor-management partnership had the potential to strengthen the local union by involving its members in an intensive process of work redesign that was predicated upon valuing their expertise and insight.

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

Since their introduction in 2006, the structure, content, and scope of MUPs activities have been altered significantly. In the first three training cycles of MUPs (referred to as "waves") from 2005 until 2008, four units were selected to undergo the process and were paired with their own MUPs facilitator. Teams would work separately and there was not a large amount of collaboration between units. Furthermore, the teams were asked to examine all of the major functions of their unit and then determine the areas for which they would develop interventions. At the conclusion of the cycle, the MUPs team shared their recommendations for change with others on the unit to get their approval. Additionally, the President of VFNHP and the Chief Nursing Officer of Fletcher Allen were required to sign off on the recommendations of the MUPs teams regarding issues of staffing, budget, and any related collective bargaining issue before these recommendations could be implemented. This approach gave teams a remarkable amount of freedom to address any and all problems they identified on their units and necessitated developing unique metrics to track the progress of their improvement initiatives. However, the process was unfocused and inconsistent which made it difficult for teams to finalize their recommendations and come to an agreement with the hospital for implementation.[60]

The MUPs structure and process shifted significantly in 2008 to emphasize providing nurses with the opportunity to learn tools and techniques to implement change on their units and building a more collaborative culture throughout the hospital. Secondary goals were to expand the ability for MUPs teams to learn from each other, to develop an infrastructure to support the quality improvement activities initiated by the teams, and to reduce the time for training. To this

[59] Interview with Jennifer Henry on 4/27/11.

[60] Ibid.

end, Fletcher Allen and VFNHP agreed to continue MUPs using one consultant who is currently Bonnie Walker of the Tupelo Group.

Since 2008, MUPs has used the following format: four units are chosen to meet seven times in day-long sessions for a period of six months. Of these seven meetings, five are "learning sessions" which are organized to provide training, access to patient care and budgetary information, and time to develop recommendations and test them. The remaining two sessions are comprised of a kick-off orientation session and an Outcomes Congress a few months after the completion of the final learning session. The Outcomes Congress provides teams an opportunity to share their experience and recommendations with other union and hospital leaders as well as staff from other areas of the hospital. All training sessions are facilitated by Bonnie Walker, the external consultant, and one or two union designated union coordinators and the director of nursing attend all learning sessions. Other healthcare professionals such as physicians attend work sessions on an as-needed basis and the union is available between learning sessions for consultation.

Each MUPs team consists of the following staff members: one director, one nurse manager, one nurse from each shift or unit location and one nurse educator. These team members are elected by their co-workers and are responsible for representing their unit. Team members communicate with the nursing staff on their unit throughout the MUPs process using tools such as communication trees (similar to the tools used at Kaiser Permanente), a physical communication area (such as a cork board in the department's break room), surveys, inviting guests to MUP team meetings, and initiating opportunities for soliciting ideas and feedback from the unit as a whole. Communication between MUPs teams during the training and planning meetings is enhanced by the fact that all four teams work and learn together in the same room. Bonnie Walker encourages teams to "steal shamelessly from each other" and links up teams working on similar problems.

The current goals of the MUPs are to build a collaborative culture in each unit of the hospital that will eventually spread to outpatient clinics and to build a system-wide approach to quality improvement. The key tools that MUPs team members are equipped with to make change on their units include: using the Relationship-Based Care model to improve the patient experience, the use of the common quality improvement approach of "Plan, Do, Study, Act" to establish a flexible change process, and the concept of Clinical Microsystems to target specific improvement efforts.[61] Teams also use online tools such as a shared drive for disseminating templates and other materials across teams.

MUPs teams are asked to focus on specific areas of improvement. They tackle two system-wide issues by choosing projects related to infection prevention and communication and two unit-

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

based issues. In addition, teams identify "low-hanging fruit" which refer to easily surmountable problems on the unit that lead to workarounds, clinical errors, and staff dissatisfaction. In order to focus the improvement efforts of the teams, all staff members from their respective units are asked to fill out a core process survey to identify key problem areas on the unit before the MUPs cycle begins.[62] Additional data regarding patient satisfaction, staff satisfaction, nursing quality indicators measured by National Data Quality Indicators (NDQI), other unit-specific surveys, and external research is also gathered at the start of and during the MUPs cycle. MUPs team members use information extracted from these varied sources to inform their choice of quality improvement projects so as to be most responsive to unit needs and to national quality standards.

Each MUPs cycle is a six month process. Once MUPs team members come up with their solutions the unit's Professional Practice Council (PPC), which is similarly comprised of nurses and nurse managers, is responsible for implementing and sustaining the changes.[63] The PPC is a permanent group whose configuration and roles differ by unit.

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

Model Unit Process Activities

Baird 3 (Orthopedic and Urology Surgical Unit), Projects and Outcomes

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

As were all teams during wave 5 of MUPs, Baird 3 was asked to concentrate on developing projects to improve communication, infection control, and two unit-specific issues. Due to palpable tension between Baird 3 and the Post-Anesthesia Care Unit (PACU) staff, unsafe patient transfers to the PACU and lack of time for nurses to complete the admission process to the PACU, Baird 3 decided to focus its communication improvement efforts on relations between Baird 3 and the PACU and the achievement of an 85% complete PACU admission rate. The team diagrammed the admission process and used data collected from the Core Unit Process Survey administered before the beginning of the MUPs, the PACU satisfaction survey and other sources to develop possible solutions to the communication gap between Baird 3 and the PACU. Ultimately, the team decided to test the implementation of pairing Baird 3 and PACU nurses,

[62] See Appendix C.

[63] At the time of publication in November of 2011, VFNHP was in the process of restructuring the organization and composition of the PPCs and other nursing councils at Fletcher Allen.

daily rounding and real-time communication between the Baird 3 and PACU charge nurse, and a LNA responsible for handling admissions to the PACU. The unit is still in the testing phase of the efficacy of these suggestions.

In addition to improving communication with the PACU, Baird 3 chose to reduce its patient fall rate to 2 falls per 1,000 patient days for one of its unit improvement goals. Prior to the MUPs process the unit's fall rate in 2010 was 3.07 falls per 1,000 patient days which was above the Fletcher Allen target fall rate. In order to reduce the unit's fall rate, the MUP team implemented the following changes: use of bed alarms according to policy for all patients, LNA and RN alternating hourly rounds, charge nurse responsibilities to include the printing of a list of fall risk patients and monitoring bed alarm use of fall risk patients, and posting a list of fall free days in the nurses' station to keep staff focused on preventing falls. After the completion of the MUPs process, the team recommended that the unit continue the new roles and activities listed above. Baird 3 also joined Fletcher Allen's Medical/Surgery unit falls group and the unit's practice council will continue to review fall rates at its monthly meetings and discuss the unit's sustained approach to fall prevention. Baird 3 falls data collected during the MUPs period indicates that the unit was able to attain a fall rate of 2 falls per 1,000 patient days in January and February, 2011.

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

Fanny Allen Operating Room, Projects and Outcomes

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

Because the unit does not actively contend with infection control problems, the Fanny Allen OR MUPs team decided to focus its designated infection control project on sustaining normothermia, the maintenance of a patient temperature equal to or above 36 degrees centigrade upon their arrival in the Post-Anesthesia Care Unit (PACU). The team analyzed Medicare reimbursement data which indicated that patients who are warmer during their surgery spend less time in the

hospital as sustained normothermia promotes healing and reduces surgical site infections. In order to promote normothermia, the MUPs team decided to introduce patient use of thermalite hats and warming blankets and to study the difference in patient body temperature with these additions. The use of the thermalite hats and warming blankets contributed to elevated patient body temperature and the team plans to continue their use on the unit.

As was noted in above, in many cases a unit's PPC is responsible for monitoring and tracking the activities implemented by the MUPs team. In the case of the Fanny Allen OR, however, the unit did not have a pre-existing PPC. The MUPs team decided that, in order to establish a consistent means of communication for unit staff and to facilitate the continuation of work begun during the MUPs cycle, they would devote their communication project to developing the infrastructure of a unit PPC. To this end, the team suggested that the PPC have bi-weekly meetings, be staffed by two RNs, one scrub technician, a nurse educator, a nurse manager and a nurse director, and include one member who had been a MUPs participant.

The lack of a PPC in the Fanny Allen OR points to one of the larger current challenges to MUPs. As will be discussed in the following section, there is little accountability for follow-up work to MUPs activities due to the fact that there is no explicit handoff between the unit PPC and the MUPs team and, in some units, the PPC is not operational. Nevertheless, MUPs provided the Fanny Allen OR with the opportunity to think about how to sustain quality, communication and work process improvement on the unit and the chance to engage nursing staff members in this work.

Inpatient Psychiatry, Projects and Outcomes

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

For its infection control project, the Inpatient Psychiatry MUPs team tackled a nationwide issue that had particular resonance on their unit: bedbug infestation. Inpatient psychiatry patients are a population specifically at risk for introducing bedbugs into the hospital and staff surveys revealed that inpatient psychiatry staff were dissatisfied with the process of handling patient belongings on the unit. The team reviewed the process of handling patient belongings and made the following alterations: patients' belongings were bagged and stored on the unit, patients were screened for bedbug exposure, social workers alerted those bringing belongings to bring them in plastic bags and to pack no more than three changes of clothes, and belongings were searched in a designated non-carpeted area. These measures exceed Fletcher Allen's current bedbug prevention policy and the unit's PPC has continued to implement these changes after conclusion of the MUPs cycle.

Members of the inpatient psychiatry team also looked to the results of their core process survey completed before the MUPs wave began and found that nurses were dissatisfied with the way in which multidisciplinary rounds were being conducted on inpatient psychiatry's two floors. Problems such as communication breakdown between shift, excessive time spent on rounds and lack of awareness of all aspects of a patient's care progress were impacting continuity of care, communication, and effective discharge planning on the unit. The team collaborated with business students from the University of Vermont who visited the unit to study the multidisciplinary

The Financial Impact of Nursing Turnover

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

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

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

rounds process and to make recommendations as to how it could be streamlined. Using the study conducted by the business students and their own input, the inpatient psychiatry MUPs team altered the rounds process so that nurses would attend rounds for specific patients and a clinical nurse specialist would consult on complex patients after the rounds meeting. The team also recommended a trial elimination of the rounds communication book to encourage nurses to speak with each other in person during the rounds meeting.

The inpatient psychiatry's work to restructure multidisciplinary rounds highlights the impact that a labor-management partnership, even when it is primarily intended for nurses and nurse managers, can have on all staff members in a unit. The new approach to multidisciplinary rounds "really broke the system for all of the staff on the unit" says Lauren Tronsgard-Scott (manager, Inpatient Psychiatry) and nurses are refusing to return to the old model. Partnership has the potential to transform the way that staff members communicate and work together, especially when physicians and specialists collaborate with nurses and other front-line staff.[64]

Hospital-Wide Outcomes

The combination of the unionization of Fletcher Allen's RNs and LPNs in 2003 and the establishment of MUPs in 2006 has had a significant impact on nurse staffing ratios and turnover. Before VFNHP organized a bargaining unit and later drove the creation of a labor-management partnership, working conditions for nurses at Fletcher Allen were unfavorable. Many local nurses chose to travel to hospitals farther afield rather than working at Fletcher Allen which left 225 nursing positions open in 2006. Turnover was high as new nurses quickly left the hospital to seek employment elsewhere. In addition, the hospital consistently relied upon the use of "travel nurses," non-local nurses who travel to a location for temporary, short-term employment. Hiring such nurses is costly and creates inconsistencies for healthcare organizations but, in 2006, Fletcher Allen employed at least 125 travelers. As MUPs developed as an initiative charged with giving nurses a voice in the workplace and making specific changes to work environment and clinical practices, conditions at Fletcher Allen began to improve. At the time of publication, there are no travelers hired by Fletcher Allen, limited open positions, and a low nursing turnover rate.

MUPs work has been able to transform working conditions for nurses at Fletcher Allen because it aligns unit-based and hospital-wide quality improvement initiatives. All teams have the responsibility to address issues that are specific to their unit alongside those that align with hospital wide initiatives such as infection control and communication. Quickly removing barriers to providing high quality care and to a safe and effective workplace by correcting easily surmountable problems (referred to as "low-hanging fruit") has energized MUPs team members and unit nursing staff to make deeper changes guided by MUPs goals.

[64] Interview with Lauren Tronsgard-Scott on 4/27/11.

Impact of and on the Union

VFNHP's commitment to securing appropriate staffing ratios for all staff and their creative reaction to the hospital's unsatisfactory compliance with the 2003-2006 collective bargaining agreement were the forces which compelled the hospital to agree to undertake collaborative labor-management work. The union continues their strong presence throughout the MUPs process. As was mentioned above, VFNHP representatives serve as coaches for the teams, providing them access to union input when needed and answering questions in terms of roles, responsibilities, and accountability. Although MUPs is a joint effort involving VFNHP, Fletcher Allen hospital administration, nurse managers and nurses, it is clear that the union has contributed a considerable amount of time, resources, and leadership support to ensure that the activities are successful and productive for team members.[65]

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

From a union-building perspective, MUPs work has been a conduit to instituting appropriate staffing levels in many departments throughout Fletcher Allen. As was mentioned previously, there are no longer travelers at the hospital and there are a reduced number of open position postings. Union membership has increased by 12% since inception of the MUPs process and, perhaps more importantly, member morale has been elevated.

Current Challenges

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

1. **Limited scope of teamwork**: MUPs have created the venue for collaboration and teamwork between nurse managers and nurses at Fletcher Allen. Unit teams may also invite a physician or healthcare professional to sit in on their meetings or to offer advice and support. Beyond this infrequent inclusion of physicians, an invitation to participate in collaborative efforts is rarely extended to other healthcare professionals who work alongside nurses at Fletcher Allen. Because MUPs is part of the union's current collective

[65] The union pays for half of the external consultant's costs for training and coaching activities.

bargaining agreement with the hospital, management has been reluctant to expand the process in its current form to include other front-line staff and managers. The hospital honors the contract and has not attempted to use the MUPs process to bring together all healthcare providers on a regular basis. In order to deepen the quality improvement work and the collaborative environment fostered by MUPs activities, it will be important to find ways to include other front-line staff members and managers or to solicit their input and knowledge of work processes on a more consistent basis.

2. **Sustaining work:** Over the course of the MUPs cycle, each unit's team researches and tests ways to make improvements to quality of care and workplace environment. The MUP cycle culminates with the team presenting formal recommendations to the department and having the President of the union and director of nursing sign off on the recommendations after feedback is received from staff in the department. However, because MUPs is only a temporary process, there is a widespread problem of a lack of follow up to insure that agreed-on recommendations are implemented and sustained. In theory, the unit's Nursing Professional Practice Council (PPC) is responsible for following up on the recommendations made by the MUP and tracking their implementation. Some PPCs have embraced this handoff and have established a process to monitor the initial recommendations of their MUP alongside establishing continuous quality improvement activities. However, many PPCs have not focused on monitoring and ensuring the MUPs recommendations are implemented. In addition, some PPCs do not exist or meet erratically. Overall, there is no clear process for sustaining initial MUPs activities and expanding quality improvement through the PPCs.

3. **Poor documentation:** Another process gap that has developed for both the MUPs teams and PPCs is that documentation and tracking of the implementation and impact of the initial MUPs recommendations is weak and, in many cases, nonexistent. No complete list of the units that have undergone the MUPs is readily accessible nor are the results of the MUPs work known to others in Fletcher Allen's hospital and clinics. Similarly, there is no centralized repository for cataloging the changes that MUPs teams have established in their departments or for the agreements signed by the union and the Fletcher Allen administration. Several teams have still not completed their recommendations for final approval and there does not seem to be urgency for them to do so.

4. **Limited staff orientation, education, and communication:** Many nurses who have been through the MUPs process commented that their orientation to MUPs, education about its purpose, and communication during the process was inadequate. First, before beginning MUPs activities, each unit is asked to fill out a Core Process survey which is later used to guide the improvement projects developed by the MUPs teams. Some MUPs team members commented that they were unaware of the purpose of the core process

survey when they were filling it out. Therefore, the survey was less useful to them as they attempted to develop projects tailored to the needs of their unit. MUPs team members suggested that the team or unit be allowed to edit the core process survey before it is administered to be able to contribute unit-specific questions and to eliminate those questions that were not applicable to their unit in order to gain the most actionable knowledge from the results of the survey. Second, some team members noted that they did not have significant knowledge about what the MUPs process would look like and what the responsibilities were for MUPs team members. This has made it difficult at times to recruit nurses for several MUPs teams. There also seems to be a lack of orientation and education of unit nurses who were not members of a MUP team but are expected to contribute their knowledge and insight to the MUPs process. Some teams remarked that this lack of knowledge of the goals, roles, and opportunities of MUPs team members made it difficult to engage with unit nurses during their unit's MUPs since these nurses did not fully understand what was taking place.

5. **Lack of hospital-wide communication:** While VFNHP and Fletcher Allen have committed significant resources to train and support MUPs activities, neither the hospital nor the union appears to have established on-going methods to promote the work and specific outcomes of MUPs. At Fletcher Allen communication about MUPs outcomes is weak and it is difficult to obtain information about what various MUPs cycles have accomplished. It is also unclear how informed the hospital administration is about these outcomes. As for the union, VFNHP is aware of MUP activities which are mentioned occasionally in the union newsletter. However, several union activists stated that the development and outcomes of MUPs activities are not shared on a regular basis at union membership and board meetings though there is has been an increased push to share MUPs updates at union board meetings. If the outcomes and use of MUPs were more actively shared and celebrated in the hospital by both union and management leaders, nurses and their managers might feel that their efforts are highly valued. In addition, new units entering the MUPs process would perhaps be more motivated to embark on a team-building and quality improvement journey that is strongly endorsed by both their union and hospital.

Conclusion

The institution of MUPs activities at Fletcher Allen Health Care is a testament to VFNHP's ability to devise a creative solution to resolve a staffing arbitration. MUPs at Fletcher Allen has provided nurses not only with a voice in problem-solving at the unit level but also with detailed information including a comprehensive understanding of their department's budget to which nurses do not traditionally have access and access to patient satisfaction scores, and comparative information related to safe staffing levels.

Furthermore, MUPs have provided nurses and nurse managers with concrete tools and skills to make meaningful improvements to work flow processes and clinical procedures on their units. Despite the issues concerning problems with documentation and hand-offs to the unit's Professional Practice Council, the process continues to grow, evolve and provide VFNHP with a powerful platform through which to engage its members.

MONTEFIORE MEDICAL CENTER: CMO, MONTEFIORE CARE MANAGEMENT

Background

From a healthcare perspective, the borough of the Bronx, New York is home to one of the most challenging populations in the United States. With approximately 1.4 million residents, eighty percent identify as either Black or Hispanic and more than thirty percent subsist below the poverty line.[66] Bronx residents contend with the increased instances of chronic disease such as diabetes and hypertension, higher mortality rate and poorer health outcomes associated with disadvantaged socioeconomic status and rely heavily on government-funded health insurance to cover their complex care needs.

Montefiore Medical Center, the university hospital for the Albert Einstein College of Medicine, serves the population of the Bronx and Southern Westchester at various locations throughout the area with its three general hospitals, a children's hospital, twenty one outpatient Medical Group sites, an acute rehabilitation unit and a home health agency.[67] Montefiore's mission is "to heal, to teach, to discover and to advance the health of the communities we serve" and the medical center has a longstanding commitment to providing integrated, community-centric healthcare services that extends beyond the traditional purview of most academic medical centers.[68]

In addition to its progressive social mission, Montefiore's approach to labor-management relations is also innovative. The medical center is a member of the League of Voluntary Hospitals and Homes of New York (LVHH), the bargaining agent created in 1968 for medical centers, hospitals and nursing homes in the metropolitan New York area. As a member of LVHH, Montefiore is engaged in the labor-management partnership initiatives of the League and Service Employees International Union Local 1199 (1199 SEIU). Montefiore was the first New York

[66] City-Data, http://www.city-data.com/city/Bronx-New-York.html.

[67] Spencer Foreman, "Montefiore Medical Center in the Bronx, New York: Improving Health in an Urban Community," *Academic Medicine* 79, no.12 (2004): 1155.

[68] Montefiore Medical Center, http://www.montefiore.org/whoweare/vision/.

City medical center to grant recognition to unions voluntarily and union officials have praised Montefiore leadership for its commitment to labor-management partnership.[69]

Over 15 years ago, as part of its efforts to offer more comprehensive care, chronic disease management services, and now behavioral health services, Montefiore organized its employed and voluntary physician network into an Integrated Provider Association (IPA) for the purpose of entering into financial risk (capitation) contracts with managed care plans.[70] They similarly arranged their psychiatrist and psychologist into an analogous group known as University Behavioral Associates (UBA). At the same time, the Care Management Company (CMO) was created as a subsidiary of Montefiore to provide administrative support to the IPA and UBA in the form of customer service, contracting, provider relations, credentialing, claims payment, financial management, data analysis, care management and reporting. The CMO was also designated to manage capitated contracts with the IPA and UBA, healthcare institutions, and managed care plans. Currently, Montefiore, its IPA, and UBA have capitation contracts with Medicare, Medicaid, and commercial plans that cover close to 150,000 individuals and generate an associated $750M in capitation payments.

> "Montefiore views service to the community as one of its cardinal commitments and explicitly names it with patient care, education, and research as the fourth tenet of its mission."
>
> Spencer Foreman
> "Montefiore Medical Center in the Bronx, New York: Improving Health in an Urban Community." *Academic Medicine* 79.12 (2004): 1154-1161.

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

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

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

[70] Capitation refers to a method of paying for healthcare services in which a fixed amount of premium dollars per designated period of time are given to healthcare providers to cover care expenses for an individual regardless of whether that individual accesses those services or not.

and their involvement in quality improvement initiatives.

Brief History of the CMO

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

In addition to drain of physicians away from the borough, Montefiore witnessed a changing economy in the early 1990s that challenged the financial security of the medical center. The revenue generated by the hospital ceased to cover its expenses and there was significant management turnover. It was also anticipated that Medicare and Medicaid payments would continue to erode their revenue due to declines in reimbursements from these government programs. Montefiore was in need of a model for providing care that would promote growth in market share, reduce leakage of patients to hospitals outside the Bronx and allow the medical center to staff top doctors, scientists and other professionals to support its mission to provide high quality care to its community, and, as an academic medical center, to conduct leading edge research and to train future physicians.

The national rise of health maintenance organizations (HMOs) in the 1990s and the medical center's perilous financial situation caused Montefiore to consider a managed care initiative to combat the loss of physicians and decreased revenue stream. The ideology behind HMOs which stresses the importance of the primary care physician as a director of patient care resonated with Montefiore's social justice and community action value system. As past Montefiore president Spencer Foreman notes, the medical center "has a long history of taking services beyond its own walls and creating programs that go beyond the traditional medical mission. Montefiore views service to the community as one of its cardinal commitments and explicitly names it with patient care, education, and research as the fourth tenet of its mission."[71]

With both economic and social justice elements as motivating factors, Montefiore created the Integrated Provider Association (IPA) and University Behavioral Associates (UBA) in 1995 which is a virtual entity consisting of the physicians employed by the hospital and many community-based physicians. Insurance companies contract with the IPA and UBA to provide a certain amount of premium dollars per member per month to be used to pay for healthcare

[71] Foreman (2004), p.1155.

services for each member attributed to the IPA and UBA. This process is referred to as "accepting financial risk" for the provision of patient care.

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

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

Labor-Management Partnership at the Contact Center

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

Before the CMO entered into a risk sharing agreement with HIP in 2000, customer services at Montefiore were divided into two telephonic centers: the first was referred to as "member services" which employed six to seven representatives and typically dealt with calls from healthcare providers' offices concerning claims. The second was a physician referral center which reported to provider services. When the CMO signed a contract with HIP, the two telephonic centers were combined into a single center which is now known as the Contact Center. The staff of this Contact Center was expanded to twenty people who took on the new the role of "customer service liaison," the majority of which were internal hires. [72]

[72] A second expansion occurred around 2002 when the call center began to handle patient billing inquiries in a centralized fashion. The CMO used the contact center to help administration understand the scope of access issues in the delivery system, including both the ease with which physician offices could be reached and the timeliness of appointment availability. In order to gather data on this, the call center did some "secret shopping" (gathering data on access and availability of appointments by calling physicians' offices requesting an appointment) and revealed that there was a systems problem, particularly because Medicaid managed care has specific requirements regarding

Since the growth of the Contact Center in 2000, there has been a strong commitment to labor-management partnership as evidenced by the increase of good union jobs available at the Contact Center.[73] The CMO entered negotiations with 1199/SEIU in order to have all customer service liaisons represented by the local union and the department has grown to employ roughly 100 staff members. Currently, four customer service liaison delegates facilitate dialogue between 1199/SEIU and the Contact Center and are empowered to organize monthly labor-management meetings which are also attended by supervisors, staff and the union organizer when schedule permits.

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

Labor-management partnership at the Contact Center also yielded a career ladder and non-punitive promotional strategy in which each level move corresponds to an expanded skillset and increased remuneration. The career ladder consists of three level moves (from level I to III) which are tied to a customer service liaison's customer service skills, knowledge of the functions of the department, and knowledge of the functions of the CMO and IPA overall. Employees also have the opportunity to return to a lower level after they have been promoted if they so choose or if they cannot maintain the skills necessary to remain at a certain level. The progressive structure of the Contact Center's career ladder ensures that all customer service liaisons "have an opportunity at career growth through [the department's] level move process…In this way [the department strives] to create an environment of opportunity, success and growth for all associates."[74]

While 1199/SEIU and Contact Center leadership collaborated to develop the values and promotional structure of the department, they also worked closely together to establish programs that would improve the quality of work life for customer service liaisons by responding to their needs. Such initiatives include introducing two start and end times so that employees can balance the demands of work and home; implementing a "3 o'clock stretch" and other activities to keep employees physically active despite the sedentary nature of their work; and celebrating national

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access. From 2002-2006 the call center expanded to provide centralized appointment scheduling services to seven medical group sites and will soon cover the whole medical group.

[73] Customer service liaisons are currently the highest paid clerical employees at Montefiore.

[74] CMO Customer Service Department, "Guidelines for Liaison Level Relegation," 2005.

customer service week in the month of October for which the customer service liaisons raise funds throughout the year. "You feel like you are a part of something at the Contact Center," was a phrase that was repeated by many customer service liaisons, stressing their contribution not only to building a collaborative work environment in their department but also to improving the productivity of and services offered by their department.[75]

> "Once you empower people, their whole mindset changes."
>
> Customer Service Liaison, CMO Contact Center. Interview on 8/26/11.

Impact of and on the Union

The labor-management partnership at the CMO's Contact Center has had a positive impact on quality improvement, customer service and access to the services provided at Montefiore. The Contact Center has rigorously documented the quality of its calls and the performance of its staff since its expansion in 2000 rendering transparent the areas in which joint labor-management work has influenced quality improvement. From 2005 to 2010 the Contact Center was able to improve its overall call quality score measured on a 100 point scale by an internal evaluation rubric from 85 to 90.[76] For its total inbound calls the Contact Center has been working towards attaining a goal of 5% calls abandoned, an average time to answer of 30 seconds and 80% of calls answered within 30 seconds. For the past year and a half the Contact Center has attained the 5% calls abandoned goal with an average time to answer of 44-41 seconds and 72-73% of calls answered in 30 seconds. The Contact Center is also working to reduce the costs per inbound call and the costs per contact which includes inbound calls, outbound calls, email and in-person contact. The figures in these areas have increased in recent years after a period of decline in the early 2000s due to capital depreciation of the Contact Center's infrastructural investments. However, the figures continue to be lower than those recorded at the beginning of the Contact Center's expansion. In 2010 the cost per inbound call was $8.57 whereas it was $9.94 in 2002 and $6.85 at its lowest point in 2006. Similarly the cost per contact in 2010 was $4.06, $7.62 in 2004 and $5.02 in 2007.

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

[75] Interview with Customer Service Liaison (anonymous) on 8/26/11.

[76] Unfortunately, no comparative data exists prior to 2000.

Center to offer its services to other departments and programs within Montefiore outside of the CMO without having to enter into arbitration to change job descriptions.

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

Current Challenges

1. **Engaging new employees:** Because the Contact Center's collaborative culture, values, and career ladder have already been fully developed and are strongly in place, Contact Center leadership and 1199/SEIU now must consider how they introduce a new customer service liaison hire to the department's unique environment. Moving forward the union and Contact Center leadership must discover ways in which they can maintain a high level of staff engagement and excitement for the labor-management partnership at the Contact Center.

2. **Extending partnership within the CMO:** Although the relationship between labor and management at the Contact Center is strong and positive, similar relationships do not exist throughout the CMO. Specifically, the New York State Nurses Association (NYSNA, the union who represents the Clinical Care Coordinators and nurses at Montefiore's hospitals and the nurses who serve as telephonic care coordinators) has had an acrimonious relationship with the CMO and Montefiore's management for several years. Some nurses who perform care management within the hospital and are represented by NYSNA feel that they have not been consulted in terms of defining and shaping their roles and responsibilities. They believe that the CMO and Montefiore have not actively taken into consideration their opinions and they mention that they feel that new initiatives and programmatic changes are simply "presented" to the nurses without the chance for incorporating their input.[77] CMO executive leaders, on the other hand, feel that the input of NYSNA nurses has been actively sought and incorporated into program development. Finding more effective processes to engage and solicit the input and expertise of the nurses working in the hospital and outpatient clinics and as telephonic care managers will be an essential approach to improving labor-management relations across the CMO and spreading the quality improvement outcomes that have been already attained by the staff of the Contact Center.

[77] Interview with Customer Service Liaisons and managers on 6/9/11.

Conclusion

Labor-management partnership activities at the CMO's Contact Center have had a considerable impact not only on the ways in which labor and management work together but also on the Contact Center's overall work environment and processes. Because the Contact Center's leadership and 1199/SEIU have worked closely together since the unionization of the Contact Center's workforce in 2000, the union and its members have had a large role in shaping the staffing levels and goals of the department. Staff members feel that their voices are heard and that they have a receptive management partner who will listen to their concerns and issues even if they express that there are problems in their provision of customer service. The Contact Center's tradition of promoting within fosters a culture of solidarity and understanding between labor and management as managers understand what it is like to have been in a customer service liaison position. Finally, both staff and managers feel like they are innovators and leaders in terms of developing collaborative work processes and an effective customer service approach that serves both the CMO and Montefiore as a whole.

Activities at the Contact Center have proven successful in terms of leading to positive environmental outcomes and, therefore, could provide a model that could be replicated elsewhere in the CMO. The export of the Contact Center's culture of collaboration which encourages staff buy-in to a set of values that foster partnership could have a powerful impact on labor-management relations throughout the CMO.

CUMULATIVE OUTCOMES

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

1. **Clinical Processes:** At San Rafael, San Diego, Fletcher Allen and Montefiore's CMO, restructuring clinical processes to be more efficient, patient-centered and cost-effective is a central goal of their partnership work and the area in which their partnership efforts have been the most successful. Initiatives across the four medical centers have engendered outcomes such as: the increase in the number of referred home care patients who are seen within 24 hours from 44% in January of 2010 to 83% in November of 2010 (Home Health Care department, San Diego), a fall rate decreased from 3.07 falls per 1,000 patient days in 2010 to 2 falls per 1,000 patient days in January and February 2011 (Baird 3 Surgical Unit, Fletcher Allen), and the achievement of 45 minute stroke alert test result turnaround time benchmark (Clinical Laboratory Services department, San Rafael). Through the labor-management joint work the four medical centers were able to devise

creative and powerful solutions that took into account the input of the front-line staff members who are responsible for many of the details of patient care to achieve these and other strong clinical improvements.

2. **Work Environment:** The institution of a labor-management partnership at the four case study sites provided a venue which had not previously existed for front-line staff and management to come together to tackle issues of quality improvement, safety, cost control, and work process redesign. Relevant trainings and an effective oversight process has contributed to the institutionalization of joint work which has led to workplaces in which front-line staff and managers felt comfortable discussing their perceptions of where and how processes could be improved on their units.

   This collaborative environment encouraged labor-management teams to find solutions to environmental problems and to improve the quality of work life at their respective healthcare systems. Notable outcomes include: zero reported workplace related injuries in 2010 and two in the first five months of 2011 (Clinical Laboratory Services Department, San Rafael), 450 overhead pages per month reduced to 422 pages per year (Operator Services Department, San Rafael), and the introduction of multidisciplinary rounds (Inpatient psychiatry, Fletcher Allen).

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

4. **Cost Savings:** An effective labor-management partnership can have a considerable impact on the expenditures of a single unit and the bottom line of an entire healthcare organization. Specific cost-savings that resulted from joint work processes include the following: $51,000 reduction in backfill costs (Operator Services, San Rafael); reduced staff turnover rate from 14% in 2008 to 3.9% in 2010 (Contact Center, CMO); reduced cost per communication contact from $7.62 in 2004 to $4.06 in 2010 (Contact Center, CMO); and reduced nursing staff turnover and traveling nurse hires (Fletcher Allen).

CUMULATIVE BEST PRACTICES AND SUCCESS FACTORS

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

1. **Proactive Union and Management Leadership:** Creating a joint labor-management process that benefits the union as well as patients requires strong and consistent union and management leadership with clear and realistic goals. Union leaders must remain focused and develop an on-going campaign to keep members engaged in order sustain partnership. The case study of VFNHP provides a clear example of the ways in which proactive union leadership can be the catalyst for the development of a strong partnership process. Jennifer Henry, past president of VFNHP, was able to use collective bargaining creatively to bring both her union's executive board and Fletcher Allen hospital administrators to support the creation of MUPs. Strong management leaders are also needed to insure that the spirit of partnership is adopted by hospital managers and administrators and that budgeting and scheduling decisions are made collaboratively.

2. **Clear Partnership Structure and Collective Bargaining Language:** A clear partnership structure is necessary to ensure that the union and its members have a direct role in decision-making, quality improvement and work process redesign projects. Collective bargaining language can help to clarify the goals of the joint work while articulating the roles and responsibilities of those involved in partnership activities. Collective bargaining language, although specific, must not be rigid and must reflect the changes in the partnership process as it evolves. Furthermore, as front-line staff and management begin joint work activities, there needs to be appropriate just-in-time education of all staff members as to their role within the partnership and how they fit into the overarching goals of the partnership. Staff members at Fletcher Allen and Kaiser Permanente note that many staff members are not fully aware of the purpose of partnership and therefore may be resistant to participation in joint work. A clearly articulated partnership process and appropriate education can counteract this roadblock to success.

3. **Institutional Support for Partnership:** One of the reasons that the Kaiser Permanente Labor-Management Partnership has been so successful at both the organizational and the unit level is due to the fact that partnership is presented as "the way business is run." Kaiser Permanente celebrates the success of its partnership activities and is constantly educating its employees about the value of partnership. The Coalition of Kaiser Permanente Unions is similarly supportive of joint work. Institutional support for partnership activities includes providing necessary education, training, access to

information, and sufficient time off-line time to dedicate to partnership initiatives for all involved in the joint work process. Institutional support for partnership from both management and labor union leaders generates enthusiasm for joint work because it gives visibility to the process, allowing staff to see that their efforts are appreciated and respected at the highest levels and helps front-line staff be connected to a shared vision for the institution.

4. **Communication and Accountability:** Since all staff members do not always have direct ways to participate in partnership activities, one of the largest challenges faced at the four medical centers was facilitating communication between those who actively participate in joint work and those who do not. Tools such as communication trees, communication boards, e-mail and huddles are essential to maintain a flow of information from core team members and unit staff and to facilitate the participation of all unit staff in partnership activities.

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

NEW ROLES FOR LABOR UNION LEADERS AND MEMBERS

Restructuring the United States healthcare system to be cost effective and high-quality will require innovative and diverse initiatives. If front-line staff are to have a strong presence in redesign work, healthcare union leaders and members will need to adopt a proactive and multifaceted approach to their engagement. It will be necessary for union leaders and members to continue to focus on traditional union functions such as collective bargaining, grievance handling, advocacy, and political action while simultaneously facilitating quality improvement and joint work projects. Healthcare unions must be seen as partners with management if healthcare unions are to remain a viable institution for patients and for their members.

In order for healthcare union leaders to become champions for joint work and quality improvement processes they need to keep abreast of research and best practices regarding healthcare policy initiatives and approaches to partnership work in order to shape their agenda.

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

The four case studies included in this report provide concrete examples and a general roadmap for healthcare unions to use to establish and expand processes to improve our healthcare delivery system. Nevertheless, continued studies and exchanges between healthcare unions with assistance, when appropriate, from researchers and practitioners can help to broaden the ways in which unions can lead patient care improvement and control costs. If healthcare unions take the initiative to share and learn from each other, hospitals and communities will see the value of unions and members will understand the extensive impact that they can have on shaping the way in which care is delivered.

TOWARDS THE FUTURE OF LABOR-MANAGEMENT PARTNERSHIPS

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

1. Cultivate strong and active labor union and management engagement.

2. Educate union members and leaders about the importance of improving the delivery of high quality and affordable healthcare as a union goal and how it aligns with other union goals. In addition, educate union members and leaders about the value and purpose of labor-management partnership work to be an innovative process not just an optimizing process and how it can help achieve a variety of union goals.

3. Customize the partnership process. Outline the structure of the partnership process and the roles and responsibilities of those involved. Select a specific or combination of approaches to focus the content and purview of partnership activities. Establish a labor-management steering committee to oversee and guide the partnership process and encourage staff participation.

4. Set clear goals that include union-building alongside specific clinical, workplace environment and relational outcomes.

5. Focus on hospital-wide (strategic) and unit-based (operational) work.

6. Create contractual bargaining language to insure the establishment of the areas of work mentioned above and to hold both labor and management accountable.

7. Negotiate specific resources to provide for internal and external consultants, coaches and educators as well as off-line time for front-line staff and steering committee work.

8. Redesign labor relations practices to establish early detection processes and a problem solving rather than a punishment process for resolving worker issues.

9. Think big but remain accountable. No matter where you start, consider partnership work as a system process to respond to the complex structures, relationships, and value systems that exist in healthcare systems. Establish a clear and practical measurement and documentation process so that workers and managers get timely feedback about how they are doing.

A NOTE ON METHODOLOGY

Research for this report was completed over an eleven month period from January to November 2011. We gathered information via group and individual phone and video conference interviews at Kaiser Permanente San Rafael and San Diego and Montefiore's CMO, group and individual

on-site interviews at Fletcher Allen and the CMO, and review of internal documents and collective bargaining agreements supplied by our contacts at all four sites.

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

When we entered the editing phase of compiling this report we contacted all those who had been instrumental in supplying us with access to information and/or had been quoted in the body of the manuscript. We incorporated feedback from these staff into the final draft of the report to ensure overall accuracy. Their input and advice throughout this project has helped us get a candid picture of the activities of all four health systems.

FOR FURTHER INQUIRY

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

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

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

Kaiser Permanente: San Diego	Labor-Management Partnership Structure	Labor-Management Partnership, Unit-Based Teams (all front-line staff and managers)
	Unions Involved in Partnership Work	-OPEIU Local 30 -UNAC -AFSCME -UFCW -Unaffiliated Optometrists Local
	Goals	-improve labor-management relations -improve quality of care -improve workplace environment -improve cost-effectiveness
	Resources and Training	-labor-management partnership orientation -interest-based problem solving/consensus decision making -rapid improvement model (RIM+) -systems of safety -business literacy -managing in a partnering environment -performance improvement leadership -effective stakeholder training -labor and management team sponsors -online tracking software
	Outcomes	-improved communication -financial transparency -collaborative work environment -internal growth for unions -staff involvement in quality improvement projects -improved clinical outcomes
	Challenges and Learning	-focus on short-term crises rather than long-term quality improvement -limited number of union sponsors -impaired communication between team members and staff

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

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

Appendix A: Kaiser Permanente

Collective Bargaining Language

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

b. Unit Based Teams

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

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

Members of a Unit Based Team will participate in:

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

The teams will need information and support, including:

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

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

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

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

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

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

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

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

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

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

Implementation Issues

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

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

Timeline

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

2006: Plan for and agree on a plan to prepare employees, supervisors and stewards to partner in Department Based Teams. Plan will cover needs for business education, training, facilitation, etc.
2007: Jointly-developed budget and regional performance objectives in place.
2008: Organization begins to see significant performance improvement attributable to DBTs.
2010: 100% of the organization operating in DBTs.

Kaiser Permanente and Coalition of Kaiser Permanente Unions, AFL-CIO 2010 National Agreement (p.6-7)

b. Unit-Based Teams

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

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

Members of a Unit-Based Team will participate in:

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

The teams will need information and support, including:

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

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

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

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

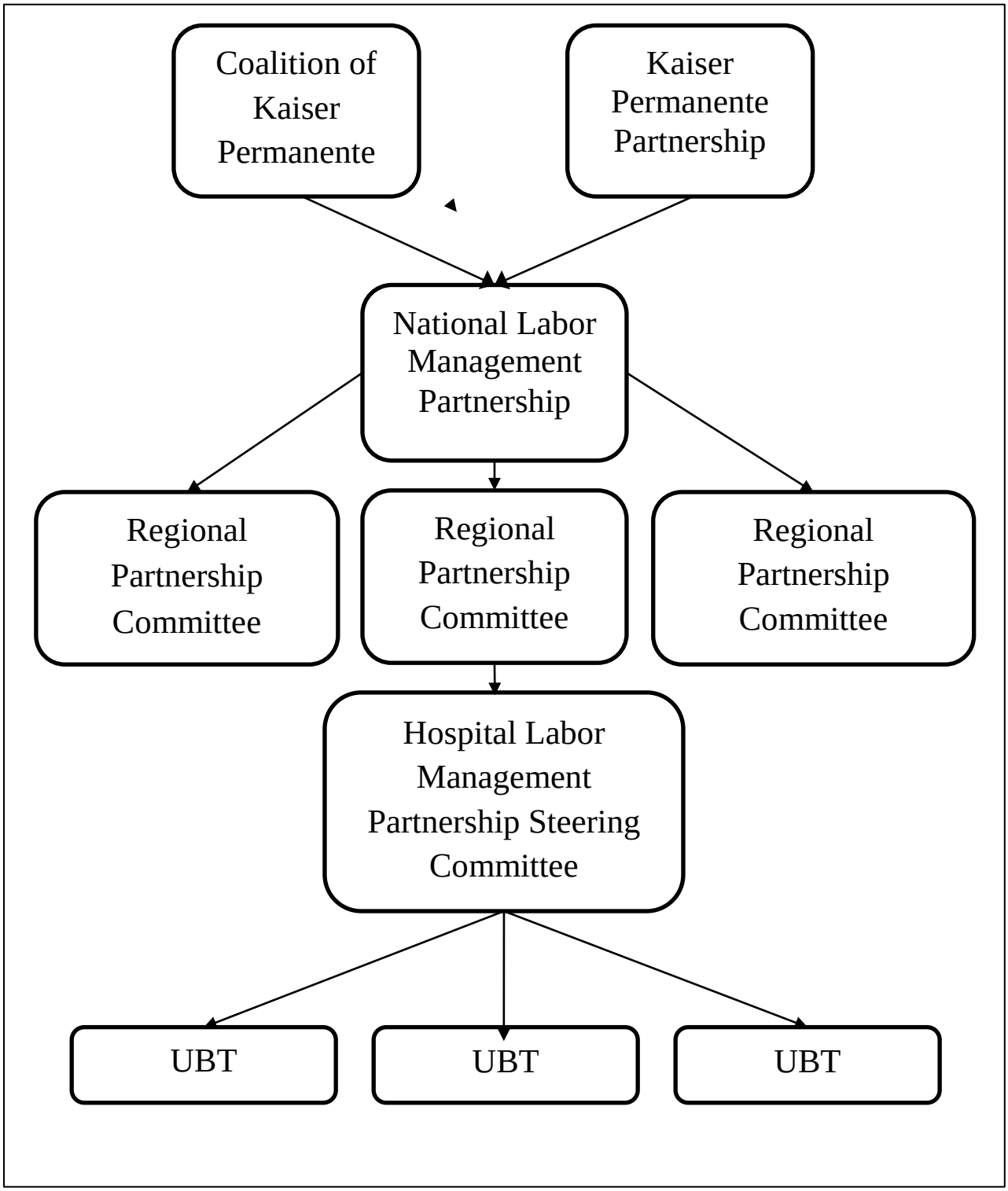
The rating system is described in the Path to Performance. (attached as Exhibit 1.B.1.b.(2))

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

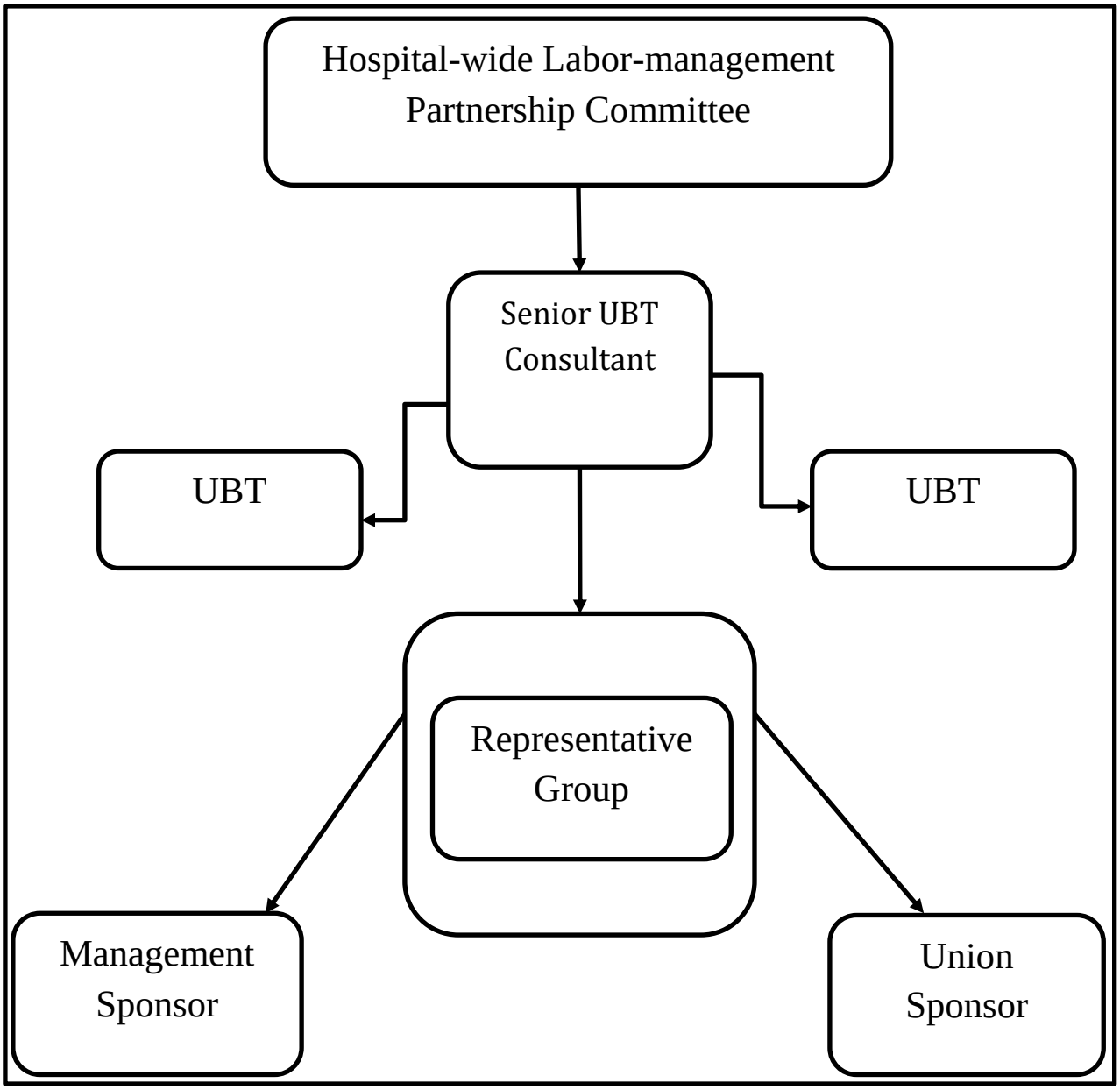
Stewards and supervisors play a critical role in high-performance partnership organizations. Where work is organized and performed by Unit-Based Teams, the roles are substantially different from those of traditional work situations. References to supervisors in this Agreement refer to management representatives.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

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

Joint Labor-Management Partnership Structure at Kaiser Permanente



Joint Labor-Management Partnership Structure at Kaiser Permanente Medical Centers



Path to Performance Evaluation Rubric at Kaiser Permanente

The Path to Performance:
Labor Management Partnership Team Development Pathway



Key Tip!

Ask yourself:

Where are your teams in the developmental process?

Who is developing and who isn't?

Why aren't they developing?

What do they need?

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

Team Development

Stages of Unit-Based Team Development

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

Guidelines for Using the Following Tool

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

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

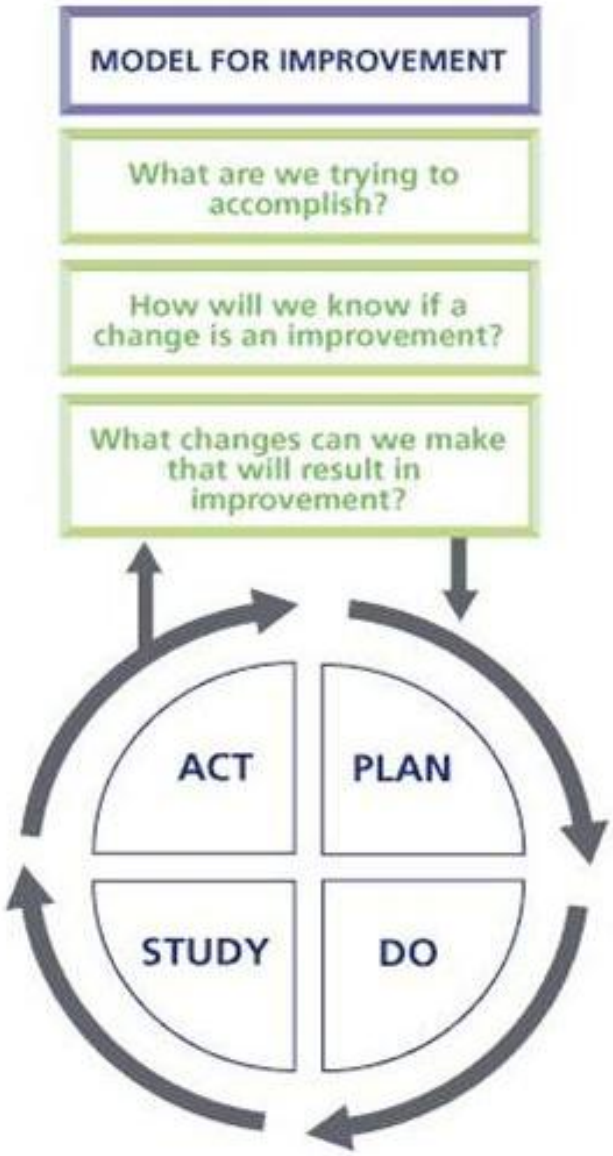
The Path to Performance:

Labor Management Partnership Team Development Pathway

Clarifications are in blue

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

Rapid Improvement Model[78]



[78] Royal College of Psychiatrists Rapid Improvement Model, http://www.rcpsych.ac.uk/quality/ctg-closingthegap/ctgprojectinformation.aspx.

Appendix B: Fletcher Allen Health Care

Collective Bargaining Agreement (2009-2011)

Schedules and Staffing
Article 20b - Model Unit Process

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

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

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

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

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

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

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

SETTLEMENT AGREEMENT

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

Background

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

Now, therefore, it is agreed as follows:

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

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

SIDE LETTER REGARDING

Joint Staffing/Model Unit Process

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

Joint Staffing /Model Unit Project Charter

1. Purpose of the Unit Committee

2. Goal (completion date)

3. Membership
   - All shifts and job classifications in the department- up to 2 nurses from each shift, the Nurse Educator and the Care Coordinator(s).
   - A VFNHP Executive Board member chosen by the VFNHP Executive Board
   - All nurses will be paid for their time in committee.
   - Department Manager, Nursing Director and one other management representative to be chosen by the management.
   - Co-chairs will be selected from union and management
   - A neutral facilitator
4. Process
   Follow the Joint Staffing/Model Unit plan template to structure unit recommendations.

5. Responsibilities of the Committee
   - Develop a unit mission statement
   - Develop a model of care that will deliver high quality care
   - Ensure that job responsibilities and duties are defined for all jobs in the unit and conform to VT State Board requirements regarding scope of practice and all relevant national nursing specialty standards.
   - Define the skills and competencies for all staff recommended in plan
   - Ensure that all affected staff has an opportunity for input and are regularly communicated with concerning progress.
   - Identify systems issues that need to be addressed to support the model unit goal
   - Identify resource and training needs
   - Develop staffing plans with the patient being the core of planning and provide supportive data, rationale etc. for recommendations. (Utilize support from staffing committee).
   - Design a community where team members share the gain and pain to meet our goal of delivering safe, high quality, competent, patient centered care.
   - Establish measures of success for the plans developed.
   - Present unit recommendations to Staffing Committee, Labor Management Committee, Magnet Committee and Professional Nursing Council groups upon completion.

6. Authority

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

Joint Staffing Model Unit Plan Template

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

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

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

4. Roles and Responsibilities
   - List the job categories necessary for delivering the model of care
   - Describe the duties and responsibilities of each of the roles
   - List competencies, training and experience requirements for each job category
   - Identify the assumptions about how the roles and responsibilities will improve patient care, management and job satisfaction

5. Staffing Model
   - Review unit/departmental budget including overtime utilization and use of traveler nurses
   - Agree on a formula to justify staffing levels that includes census and acuity
   - Provide criteria for why the model chosen is appropriate
   - Develop a detailed daily schedule, including break schedule and other needed work rules, for each of the above roles.

- Plan for replacement needs
- Plan for staff education needs, research, participation in governance, etc.
- Plan for fluctuations in staffing needs with changes in volume and acuity
- Review staff illness and injury data for the unit
- Identify the number of people needed in each job classification to fill each shift.

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

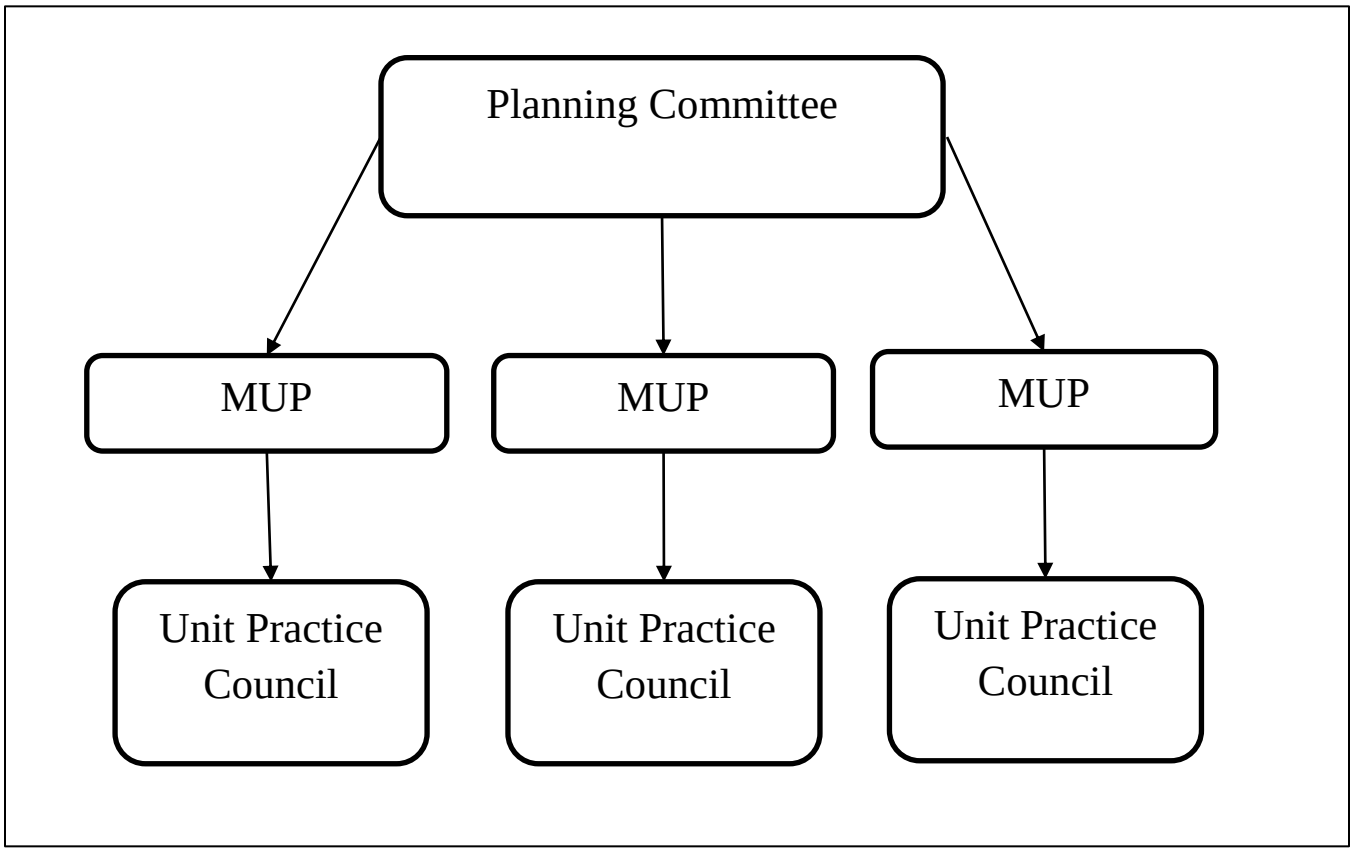
7. Define Metric/Measures of Success for the Unit
   - Current measures and targets
   - Proposed measure and targets

8. Meeting Minutes and Support Documentation

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

10. Implementation
    Identify:
    - Implementation tasks
    - Implementation dates
    - Responsibility for accomplishing the tasks
    - List the measures of success that will be used to evaluate the Unit.

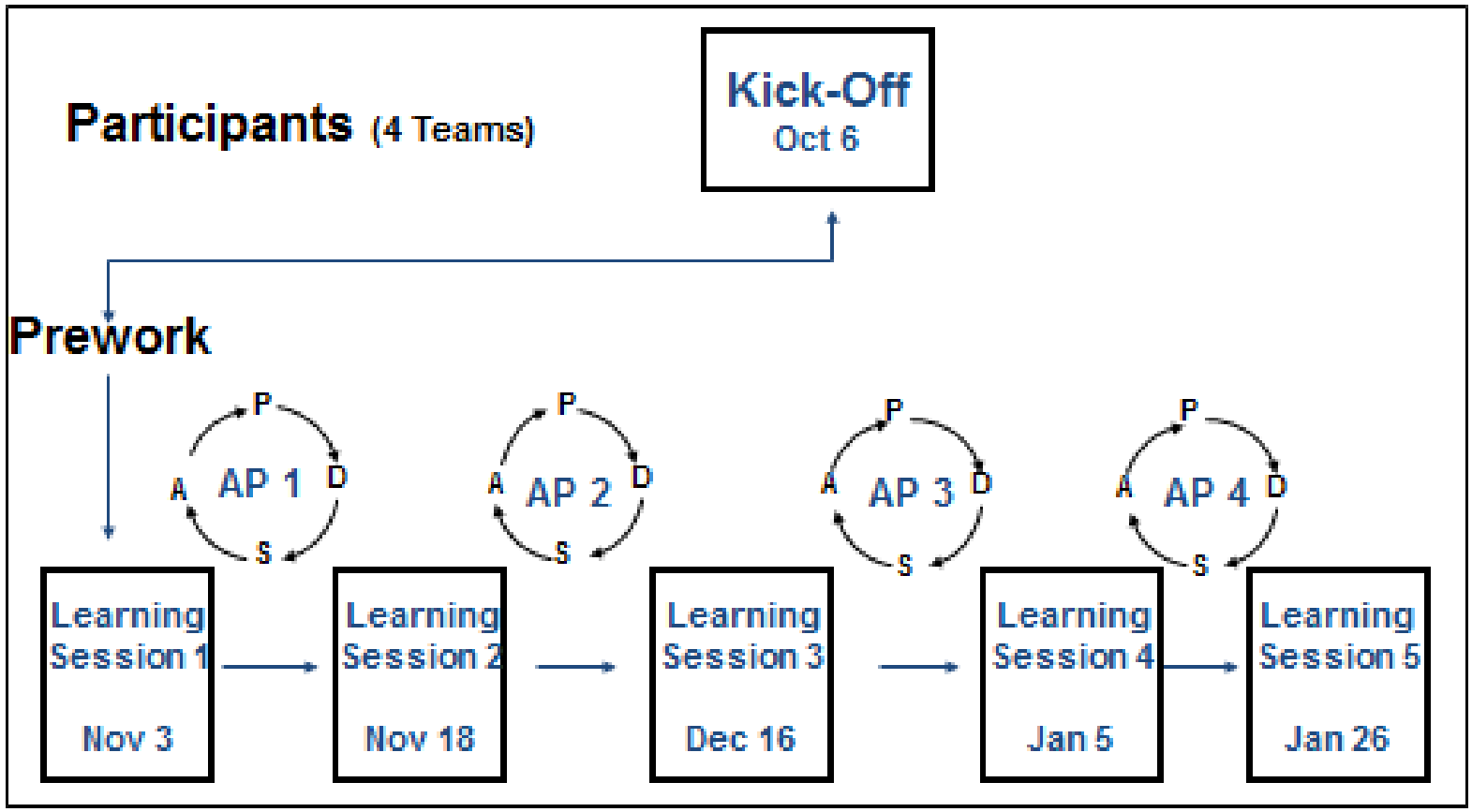
Model Unit Process Structure at Fletcher Allen Health Care



MUPs Core Process Survey

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

Our Model Unit Process Timeline



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Appendix C: Montefiore Medical Center

Timeline of CMO Development

1996: Formation of the IPA, CMO and UBA; CMO signs contracts with Aetna, Oxford, IL Care, US Healthcare, Blue Cross/Blue Shield, 1199 Professional Services Cap, United Healthcare, and PHS brining in a total of 52,000 lives

1998: CMO executive offices moved to Yonkers

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

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

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

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

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

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

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

2005: Development of patient education services

2008: Development of respiratory care management program

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

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