The Kaiser Permanente Labor Management Partnership 2009-2013

THOMAS A. KOCHAN
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Funds for this research are provided by the Kaiser Permanente Labor Management Trust Fund and the Thomas W. Haas Foundation. All conclusions and other views expressed in the report are solely those of the author.

Kaiser Permanente Value Compass
The Value Compass depicted on the cover is used to guide decision-making and problem solving at Kaiser Permanente, with the patient and KP member at the center. Developed by the Labor Management Partnership, the Value Compass is used across the organization and is included in the National Agreement between Kaiser Permanente and the Coalition of Kaiser Permanente Unions as a key operating strategy.

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EXECUTIVE SUMMARY

In 1997 the CEO of Kaiser Permanente (KP), the President of the AFL-CIO, and leaders of the coalition of the unions representing employees at KP created what was to become the largest, most longstanding, and most innovative labor management partnership in the nation’s history. This report analyzes the evolution of the Kaiser Permanente Labor Management Partnership from 2009 to the present, identifies the key challenges and opportunities that lie ahead for the Partnership, and suggests options for addressing these challenges and opportunities. As such, this report represents a continuation of the research our group has carried out on the Partnership since 2001.

History

The LMP was born out of crisis. Kaiser Permanente was facing a financial crisis as a result of persistent operating losses. Labor relations had turned highly adversarial with frequent strikes. Employees had been forced to accept wage and benefit concessions and layoffs to deal with the growing competition from lower cost health care providers and insurers. A leading consulting company had recommended Kaiser Permanente split the organization into two separate entities, and thereby abandon its half-century mission of integrating insurance and health care delivery.

These executives and union leaders chose to go in a different direction by pledging to work together on their labor relations and health care delivery challenges. Thus, the Kaiser Permanente Labor Management Partnership, what came to be known as the “LMP” was born.

Early Achievements and Limitations

Over its first decade, the Partnership helped turn around Kaiser Permanente’s financial performance, built and sustained a record of labor peace, and demonstrated the value of using interest-based processes to negotiate national labor agreements and to resolve problems on a day-to-day basis. Among its most significant achievements included negotiation of a system-wide employment and income security agreement for managing through organizational restructurings. This agreement provided the framework to support the introduction of electronic medical records technology on a scale that has made Kaiser Permanente a national leader in this area. In 2005 negotiations, the parties committed to bringing partnership principles more fully to bear on the front lines through use of “unit based teams” (UBTs) to support continuous improvement in health care delivery and performance.

At the same time, the parties made limited progress toward their shared objective of going beyond innovations in labor relations to make partnership a key feature of the operating model for delivering health care. Moreover, significant inter-union rivalries emerged that threatened continuity of the partnership.

2009-2013 Experiences and Achievements

In the past five years the parties have achieved significant progress in integrating the partnership into the standard operating model for delivering health care by expanding UBTs throughout the organization and demonstrating that high performing teams that engage employees contribute significantly to improving health care quality and service, reducing workplace injuries, improving attendance rates, and achieving high levels of employee satisfaction with KP as a place to work and a place to get health care. As a result, Kaiser Permanente is now one of the nation’s leaders in the use of front line teams to improve the health care delivery.

Two more interest-based agreements were negotiated that maintained industry-leading wages and benefits, introduced a joint commitment and program to improve the health of the workforce, and began the difficult process of limiting the rate of growth in retiree health care costs.
Challenges and Opportunities

The LMP, and Kaiser Permanente overall, continue to face significant challenges and opportunities. Four are highlighted in the report along with recommendations for addressing them.

Adapting to New Models of Care Delivery Text

The biggest and most immediate challenge and opportunity lies in adapting to the new models of health care delivery required to provide high quality, affordable care to the populations of patients soon to be covered under the nation’s new health care law, the Affordable Care Act. Doing so will require building on, but going considerably beyond, the incremental improvement processes that have proved successful in UBTs. These new models of care will need to combine use of advanced technologies and cross discipline teams to address the total health of patients through expanded community and home based services.

Kaiser Permanente has begun piloting a number of such efforts. The immediate challenge lies in learning from these pilots, and from similar ones outside of KP that are advancing across the health care industry, integrating these efforts with workforce planning and LMP processes, and implementing them where appropriate across KP’s multiple regions and worksites. The LMP needs to take responsibility for benchmarking best practices in these new care models, supporting innovation and testing of new models, learning from them, and spreading them where appropriate to help make Kaiser Permanente a leader in this emerging area of health care.

Exploiting KP’s “Big Data” Capabilities

Kaiser Permanente collects an enormous amount of data on operations within its regions and specialized professional/functional groups. Yet it has not taken full advantage of the analytic power of the “big data” it collects, in large part because of its culture of regional autonomy and functional specialization. In recent years, the LMP has demonstrated the value of integrating data on its teams, workforce surveys, labor relations, safety and health, and selected clinic performance measures. This process needs to expand and be integrated with data collected by other groups in finance, information technology, quality, and clinical operations to provide the analysis needed to carefully track, evaluate, and disseminate information on the effects of its experimentation with new health care delivery models and its on-going operations.

Leadership Transitions

Leadership transitions have proven to be an Achilles Heel for many labor management partnerships. The LMP has successfully managed through a number of leadership transitions of KP executives, Permanente medical leaders, and leaders of the union Coalition. It is currently doing so again and will continue to experience introduction of leaders new to the partnership in the future. A conscious and well executed strategy needs to be put in place for educating new management and labor leaders to the culture, principles and processes of teamwork, problem solving, interest-based negotiations, and to the shared vision of making partnership its key operating strategy—a vision characterized in the Value Compass depicted on the cover of this report.

Managing on-going Union Differences

The partnership has survived in the face of on-going rivalries between the majority of unions that participate in the partnership and several that do not and between unions competing to represent key groups of workers. In two recent elections a majority of the largest group of employees involved have voted to
continue to be represented by the Service Employees International Union and continue to express support for and satisfaction with the partnership. Yet aspects of this and other inter-union differences in philosophy and strategy continue to complicate contract negotiations, day to day labor relations, teamwork, and current and possibly future efforts to experiment with and introduce new models of care delivery. Managing and, where possible, resolving these on-going differences are shared responsibilities of all labor and management leaders at Kaiser Permanente and, indeed of leaders in the American labor movement who value this partnership as a beacon of innovation in health care and in labor relations.
INTRODUCTION

This report analyzes the evolution of the Kaiser Permanente Labor Management Partnership (LMP) from 2009 to the present, identifies the key challenges and opportunities that lie ahead for the Partnership, and suggests options for addressing these challenges. It represents a continuation of the research our group has carried out on the Partnership since 2001. To place the current research in context Figure 1 and the section below provide a brief summary of the partnership’s first decade.¹

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**Figure 1: The Labor Management Partnership’s First Decade**

<table>
<thead>
<tr>
<th>Achievements</th>
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<tbody>
<tr>
<td>◆ Decade of Labor Peace</td>
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<td>◆ Reversal of Financial Losses to a Decade of Financial Gains</td>
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<tr>
<td>◆ Initiation of Unit Based Team Process</td>
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<tr>
<td>◆ Negotiation of Employment and Income Security Protections</td>
</tr>
<tr>
<td>◆ Widespread Implementation and use of Healthconnect (Electronic Medical Records Technologies)</td>
</tr>
<tr>
<td>◆ Restructuring of Northern California Optical Laboratory</td>
</tr>
<tr>
<td>◆ Successful use of Interest Based Negotiations in two National Agreements and Wage Reopener</td>
</tr>
<tr>
<td>◆ Survival through Leadership Transitions and other “Pivotal Events”</td>
</tr>
<tr>
<td>◆ Negotiation of Industry Leading Wage and Benefit Levels</td>
</tr>
<tr>
<td>◆ High levels of support from Rank and File for the Partnership and as a Place to Work</td>
</tr>
<tr>
<td>◆ Growth in Union Membership</td>
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<table>
<thead>
<tr>
<th>Limitations</th>
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<tr>
<td>◆ Slow Evolution from a “Labor Relations” Program to an “Operating Strategy”</td>
</tr>
<tr>
<td>◆ High Administrative Costs with limited ability to measure Financial/Return on Investment</td>
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<td>◆ Inter-Union Rivalries</td>
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The Kaiser Permanente (KP) Labor Management Partnership was borne out of crisis. After a half-century of positive labor management relations, all could see that things were not only deteriorating throughout the 1990s but that they were about to spiral into an escalating war. The decision to try another path proved to be historic. The partnership’s most significant initial achievements were to replace the escalating conflicts with a decade of labor peace during which the parties put in place new labor management processes and relationships needed to meet the organizational and health care delivery challenges of the day. By the end of the first decade, the shift to a workplace focused strategy of continuous improvements through unit based teams (UBTs) and extensive implementation of advanced electronic records technologies (HealthConnect in KP terminology) made the partnership an integral part of the Kaiser Permanente health care delivery system.

The fact that the partnership survived for over a decade is an important accomplishment in and of itself. While most labor-management partnerships tend to have limited half-lives, this one demonstrated an ability to work through the various pivotal events that come along and threaten to derail, if not destroy, partnerships. These pivotal events included negotiation of a comprehensive employment and income security agreement to deal with organizational restructuring and technological changes; negotiation of a plan that both saved and improved the performance of the Northern California Optical Laboratory; successful negotiation of two national bargaining agreements (and one wage opener) after significant concern that national agreements meant threats of national strikes; continuity of the partnership through transition to both a new CEO and new Executive Director of the union coalition; response to budget crises in Southern California and several other regions; and, with help from AFL-CIO leaders, resolution of at least a truce of a bitter inter-union dispute over organizing and raiding of bargaining units involving coalition unions and the California Nurses Association (CNA). Any one of these events held the potential for derailing the partnership. But in each case the parties were able to draw on the relationships developed from working together and used their collective skills in negotiations, problem solving, and conflict resolution to work through the crisis.

In our earlier research we concluded that the extensive and creative use of interest-based bargaining in the negotiations of two national-level agreements will be recorded as historic achievements in U.S. labor relations. To date, these are the largest (in terms of number of workers, geographic scope of operations, and number of unions covered) and the most extensive (in terms of range of issues addressed) applications of interest-based bargaining in U.S. labor relations. And though the national bargaining processes required huge financial, human, and organizational resources and support, they concentrated negotiations into a single time frame, rather than requiring KP and its Coalition unions to engage in multiple negotiation processes, with a much higher likelihood of work stoppages.

Seventy percent of the union coalition members surveyed in 2007 preferred the partnership over a more arms-length labor-management relationship. Moreover, although at that time only about 40 percent of front-line workers and union members participated directly in partnership activities, those who were doing so reported higher levels of satisfaction with their jobs, union, and influence in decision making than those who were not participating in partnership initiatives.

Although Kaiser Permanente lacked the comprehensive, system-wide data needed to track the effects of the partnership on patient outcomes on a broad scale, the one such study we were able to carry out in the
Northwest region’s clinics showed that employee participation in partnership activities was associated with significant improvements in patient outcomes, such as adult and child immunization rates and breast cancer screenings.

More generally, KP benefited because the partnership taught both employees and managers important new skills in problem solving, meeting management, conflict resolution, and business understanding all valuable resources in meeting challenges KP would face in the future. These skills represented a considerable achievement from the employees’ point of view as well. The expanded training and development and opportunities for direct participation on a wide array of issues upgraded employees’ skills and abilities. Some employees took advantage of these opportunities to develop the knowledge and skills needed to become facilitators or issue specialists, such as coordinators for workplace safety and HealthConnect; some took on new leadership and representative roles within their unions or the coalition; some benefited from new job opportunities inside and outside of KP. The capacity of employees to influence decisions increased, both at an individual level and collectively, through their unions. Union leaders, at all levels, also learned new skills and gained access to the information needed to contribute effectively to decisions that heretofore were out of their reach such as the design and planning of new facilities or marketing strategies for meeting new or existing customer needs.

Employees benefited in additional ways. Wages rose at least in tandem with, and in the case of workers in lower paid jobs, more than wages of other health care workers across the country. KP workers also avoided the declining coverage and increasing costs of health care and the elimination of defined benefit pensions or retiree health care benefits experienced by many other American workers over the last decade.

The introduction of electronic medical records technologies, which many health care leaders, including those at KP, believe have a high potential to improve the quality of health care in the United States, was actively supported by the partnership. The collectively bargained agreement outlining how workforce issues would be handled in the transition and in the implementation of the new technology is a national benchmark for others to emulate. It paved the way for acceptance of the new systems and provided guidelines for involving workers and union leaders at the local level in fitting the new technologies to their specific circumstances.

The evolving partnership at KP did not eliminate all conflicts or create some idyllic world of pure cooperation. Differences in interests are a natural and ongoing part of all employment relationships, union or non-union, adversarial or partnership. To expect that workers will always go along with management directives or initiatives or that all managers will always go along with what workers or their unions want is neither realistic nor good for the long-term interests of any of the stakeholders to an organization or an employment relationship. The question is whether partnership provides a better way of addressing problems and conflicts that exist and arise than the alternatives. On this dimension KP’s labor-management partnership proved its value in the first decade of its existence.

Finally, and of particular importance to a labor movement facing continued union decline and continuous conflicts in union organizing drives, KP’s unions expanded and organized approximately 20,000 new members. Some of this growth came from expansion of employment in existing bargaining units and some came by activating the negotiated rules governing organizing of new employee groups. In doing so, KP and the coalition unions were able to avoid the diversion of scarce health care dollars from patient care to battles that enrich lawyers and consultants.
Limitations

Building and maintaining the partnership is a costly endeavor. The work of the Partnership is supported by a labor-management trust fund established under the collective bargaining agreement and funded by employee and employer contributions. In 2005 the annual budget was $16 million (this increased to $28 million in 2012). This amount does not reflect the full costs of time and energy of executives, physician leaders, union leaders and staff, and front-line managers and union representatives devoted to making the partnership work. At the same time, these partnership costs need to be compared to the potential costs of possible alternative relationships, especially the costs and risks associated with more adversarial union-management relations, the costs of union avoidance efforts in non-union settings, and the opportunity costs of not having the collective capabilities the partnership has developed. Although the direct costs and investment of time and energy needed to manage the partnership are measurable and/or visible to those involved, the avoided costs are much harder to quantify.

Partnership leaders made only limited progress in realizing their vision of evolving from a labor relations program to a full-fledged new model for delivering health care. Though the 2005 contract codified this as a major objective, as of 2008 leaders were still in the early stages of implementing it, focusing on the creation and diffusion of unit-based teams.

A major inter-union challenge to the future of the partnership was just beginning to unfold as our project ended. The Service Employees International Union (SEIU) put the California local that represented KP employees in trusteeship after a lengthy battle between SEIU national union president Andrew Stern and California local union president Sal Rosselli. This led Sal Rosselli and a number of his local union leader colleagues to resign from SEIU and to form a new union, the National Union of Healthcare Workers (NUHW). NUHW then began an organizing campaign to decertify SEIU as the representative of KP employees and to choose NUHW as their representative. That inter-union conflict continues to today and its dynamics will be discussed in this report.

In summary, we judged the first decade of the Kaiser Permanente labor-management partnership’s existence a success but still a work in progress. It turned around dangerously deteriorating labor-management relations; deepened the organizational capacity of KP to meet challenges and crises as they arose; demonstrated that workers, unions, managers, and physicians could work together in delivering high quality health care; and yielded significant benefits for management, employees, and unions. This positioned the partnership in stark and favorable contrast to the restructuring underway in other industries, such as airlines, where restructuring exacted a toll on wages, hours, and employment security of the workforce.

2009-2013

How has the Partnership fared since 2009? The good, maybe even remarkable, news is that it survived an escalating inter-union battle for members between the SEIU and NUHW and continued opposition to the Partnership by the California Nurses Association (CNA) in Northern California. The parties also continued to use interest based negotiations processes in contract negotiations in 2010 and 2012. Perhaps the most notable achievement in recent years has been the adoption and spread of front line work teams.
Significant challenges and opportunities lie ahead, particularly, as the parties search for ways to adapt to a changing health care policy environment, manage leadership transitions, and address inter-union differences related to the partnership.

**Growth and Effects of UBTs**

“UBTs have the most potential of any aspect of the organization in making breakthroughs on performance. So we’ll keep working on this.”

The 2005 negotiations culminated in a joint commitment to focus on expanding “unit based teams” (UBTs), i.e., cross function teams of front line employees (nurses, service employees, technicians, physicians, and managers) to focus on KP’s core objectives of quality, service, cost control, and a great place to work. These objectives were subsequently embodied in what is called the “Value Compass” depicted on the cover of this report.

Implementation of the UBTs started slowly as the parties worked on the infrastructure that would be needed to support them—training programs, structural guidelines, tracking and measurement systems, etc. and leadership transitions were in process on both the union and management sides of the partnership. Momentum then picked up when the new partnership leaders made this a high priority. UBTs have evolved to become the centerpiece of partnership efforts to improve health care delivery and performance. In particular, the parties, led by union Coalition leaders, created an initiative called “The Case for Change” that laid out the goals for engaging front line workers in driving improvements in health care delivery and performance. The leadership of the Coalition in proposing the “Case for Change” was acknowledged by several management interviewees.

Coalition leaders have done an important thing and I give them significant credit for drawing focus to UBTs as the significant tool by which we work together. The progress we’ve made there is encouraging, not because it has saved billions in health care cost but has the potential to be a replicable model of worker engagement for solving care and worker problems at the front line. Perhaps we could have done this without unions but for 50 years we didn’t. The union leadership brought sharper focus to this as a way of doing work.

**Quantitative Data on UBTs and Performance Measures**

Annual goals were set in 2005 to increase the numbers of teams culminating in a goal of 100% coverage by 2010. This goal was met and once it was achieved, attention shifted to increasing the effectiveness of UBTs, with targeted percentages at the “high performance” level increasing each year. Figure 2 tells much of the story. By January 2012, 3,458 teams were operating covering nearly all the units in which Coalition members work, although only some members were actively engaged as participants. One third of these UBTs were judged to be in the “high performance” category (i.e., rated either a 4 or 5 on a 5-point assessment scale). (By December 2012 40 percent of teams had reached the “high performance” level).

Analysis of the teams carried out by Kaiser Permanente’s Organizational Research staff found that compared to teams rated as a 1 or 2, those rated 4 or 5 achieved higher employee satisfaction ratings on KP’s People Pulse survey. In turn higher scores on the People Pulse survey were shown to be related with higher levels of a variety of quality of care measures including the national hospital quality survey (HCHPS), and lower rates of mortality, infection, worker injury, and absenteeism. (see Figure 3 through Figure 8).
Figure 2: Growth In High Performing Teams

**FIGURE 2**
GROWTH IN HIGH PERFORMING TEAMS

Growth of High Performing Teams 2010-2012
# of Teams at Level 4 and 5 on UBT Path to Performance

- 2012 Target = 1383 teams
- 2011 Target = 658 teams
- 2010: 329 teams
- 2011: 1097 teams
- 2012: 1581 teams

Figure 3: PP Questions Related To Outcomes

**FIGURE 3**
PP QUESTIONS RELATED TO OUTCOMES

12 People Pulse items showed up frequently as having a relationship to higher performance.*

- Greater Workforce Effectiveness
- Improved Quality
- Higher Patient Satisfaction
- Fewer Workplace Issues
- Better Attendance
- Decreased Cost
- Improved Affordability

Ranked in order of impact on outcomes.

Per cents in parentheses represent KP's 2011 favorability scores.

- 25. Efficient work procedures in dept (71%)
- 48. Know about department goals (78%)
- 38. Understand how my job contributes to our goals (89%)
- 8. Confident mgmt would respond to unethical behavior (74%)
- 39. Comfortable raising ethical concerns to sup/ mgmt (78%)
- 31. Department operates effectively as a team (71%)
- 32. Dept doing things to improve patient safety (65%)
- 29. Usually enough people in department to do job right (54%)
- 5. KP provides resources necessary to work effectively (77%)
- 26. Steps taken in dept to ensure employee/ physician safety (67%)
- 33. Encouraged to suggest better ways to do work in dept (78%)
- 41. Supervisor recognizes me when I do a good job (73%)

* Significantly correlated with half or more of the outcome measures involved in the analysis.
Figure 4: UBT Impact On PP Questions Related To Outcomes

This chart compares the performance of Level 1 and Level 4 and 5 (“high performing” teams) on the People Pulse items that were found to have a relationship to higher performance.

Figure 5: Hospital Patient Satisfaction

This chart compares the performance of Level 1 and Level 4 and 5 (“high performing” teams) on multiple H-CAHPS (hospital patient satisfaction) measures. The differences are statistically significant.
Figure 6: Patient Safety

**FIGURE 6**
**PATIENT SAFETY**

Central Line Bloodstream Infections per 1,000 Line Days

<table>
<thead>
<tr>
<th>Medical Centers Below Median on Team Effectiveness</th>
<th>Medical Centers Above Median on Team Effectiveness</th>
</tr>
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<tbody>
<tr>
<td>1.15</td>
<td>0.86</td>
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</table>

"People Pulse" Question: "My department operates effectively as a team"

This chart compares the performance of medical centers below and above the median on a People Pulse question related to team effectiveness ("My department functions effectively as a team").

Figure 7: Workplace Safety

**FIGURE 7**
**WORKPLACE SAFETY**

UBT Ranking Associated with Lower Injury Rates

<table>
<thead>
<tr>
<th>Workplace Injury Rates</th>
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<tbody>
<tr>
<td>Level 1</td>
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<tr>
<td>Level 4 &amp; 5</td>
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Injury Rate is 29% lower in high-performing teams

This chart compares the performance of Level 1 and Level 4 and 5 ("high performing" teams) on a key measure of workplace safety. The differences are statistically significant.
Managers and employees also recognize the value of high performing UBTs. People Pulse data shown in Figure 9 indicate that the percentage of managers who agree that the “LMP has helped improve organizational performance” rises from 59% for managers leading UBTs currently functioning at the lowest level of performance to 73% for managers leading teams rated at the highest level of performance. For employees (see Figure 10) in these teams the comparable numbers are 55% in the lowest rated teams and 63% in the highest rated teams. As shown in Figure 11, employees participating in UBTs also rate the LMP as more effective in improving both their work environment and the performance of their work units than employees who report not participating in a UBT. Thus the strategy of focusing on UBTs appears to be generating significant payoffs for both the workforce and for Kaiser Permanente.
Figure 9: Managers Respond to UBT Development

Managers Are More Positive About Partnership as UBTs Develop
People Pulse Item #53: "The LMP has helped improve organizational performance"
% Favorable - Managers who are Co-Leads/Members of UBTs

Figure 10: Employees Respond to UBT Development

Employees More Positive About Partnership as UBTs Develop
People Pulse Item #52: "The LMP Has Helped to Improve Working Conditions"
% Favorable - Employees who are members of UBTs
Figure 11: Significant differences exist between those who say they are part of a UBT vs. those who say they are not

<table>
<thead>
<tr>
<th>Differences Between Participants and Non-Participants in UBTs</th>
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<tbody>
<tr>
<td>Empowerment, line of sight and continuous improvement continue to be more favorable</td>
</tr>
<tr>
<td>51. Involved in LMP activities</td>
</tr>
<tr>
<td>52. LMP has helped to improve working conditions</td>
</tr>
<tr>
<td>53. LMP has helped to improve org performance</td>
</tr>
<tr>
<td>49. Can influence decisions affecting work</td>
</tr>
<tr>
<td>48. Know about department goals</td>
</tr>
<tr>
<td>50. Know about KP Mission/ Vision</td>
</tr>
<tr>
<td>41. Supervisor recognizes me when I do a good job</td>
</tr>
<tr>
<td>33. Encouraged to suggest better ways to do work in dept</td>
</tr>
<tr>
<td>26. Comfortable voicing opinions, even if different</td>
</tr>
<tr>
<td>27. Dept seeks improvements to reduce costs</td>
</tr>
<tr>
<td>30. Encouraged to speak up about errors &amp; mistakes in dept</td>
</tr>
<tr>
<td>39. Supervisor informs me about decisions and changes **</td>
</tr>
</tbody>
</table>

*Items with the largest differences  
** In 2011, item was reworded to enhance clarify

Another quantitative study carried out by colleagues at Johns Hopkins and Rutgers Universities found that primary care clinics that had high levels of participation in UBTs and in which employees actually perceived having high levels of influence in decision making achieved higher levels of performance (measured as patient wait time) than units that had only one (i.e., either high participation in UBTs or high perceived influence). These results suggest that UBTs can be an enabling mechanism for effective employee input but to achieve significant results team leaders have to make sure individual employees feel their voices are being heard.

The studies conducted by the Organizational Research Unit and by these outside researchers are among the first to demonstrate a direct link between the partnership and Kaiser Permanente's health care performance. More research of this kind needs to be carried out to continue to track and document the effects of UBTs and employee engagement on health care performance, an issue I will return to in the final section of this report.

**Qualitative Studies of UBTs**

As the studies summarized above suggest, there remains a great deal of variability in team effectiveness. Teams in Northern California are hampered by the fact that the nurses in that region are not part of the Coalition and their leaders discourage them from participating in these teams. Although the actual participation by nurses varies, this variation complicates the work of teams in that region and makes managing them more challenging than in settings where the nurses are encouraged by their union to participate.

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1 Adam Seth Litwin and Adrienne Eaton, “Frontline Teams and the Mystery of the Missing Performance Link,” working paper Johns Hopkins University School of Business and School of Medicine, November 2012.
A qualitative study carried out by a team from Rutgers University and Kaiser Permanente’s Organization Research Unit of over a dozen high performing UBTs drawn from different regions and working in different types of departments including but not exclusively patient care, identified several factors that appeared to be associated with team effectiveness. These include: (1) joint leadership and sponsorship by management and labor representatives; (2) clear “line of sight” from the team’s work to important organizational goals; (3) measurement of the teams’ contribution to those goals and team review of those measures; (4) use of both interest-based problem solving and a Rapid Improvement Model to drive change; (5) training, facilitation and metrics support; and (6) flexibility in structure, methods and scheduling. \(^3\) Likewise a follow up study of the role of UBT “sponsors” (individuals assigned the task of coaching and supporting UBTs in their facility or region) found wide variation in how this role is carried out. The authors recommended a set of individual, structural, and organizational actions to strengthen the role of sponsors. Specifically, they recommended (1) better integration of sponsor development into other leadership development programs, (2) improving the line of sight between front line workers and sponsors, (3) showcasing “big wins where sponsors help UBTs get their work done, and (4) appointment of regional executive sponsorship liaisons to improve the visibility of their work at the national level. \(^4\)

Two team leaders summarized satisfaction they and their coworkers and patients get from teamwork and from the support of their unions for UBTs. \(^5\)

“I want to go to work and be happy. You have to have harmony in your work area. If you don’t have that you have nothing. When we work together we feel good about each other (co-workers and managers) then our patients see it and feel good about their treatment as well.

The union has done a lot in our department in getting good medical coverage and good wages. The work we do in our teams reflects what we want our union to do—we want it to support our teams and our efforts to serve our patients.”

Data collected as part of the LMP’s “UBT Tracker” show teams are increasingly focused on projects aimed at improving patient care. Figure 12 provides the most recent data. Thirty percent of the projects the teams are focused on service quality, another 20 percent are focused on affordability, 10 percent are addressing attendance issues, 9 percent are addressing disease prevention or management, and 7 percent are addressing workplace safety.

Qualitative and quantitative data from team leaders and members also indicate strong support for UBTs.

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\(^4\) Many more examples of the work of UBTs and the views of team leaders and members can be found on the LMP website: www.lmpartnership.org.

The steady growth in the number and improved effectiveness of UBTs may stand as the partnership’s most significant achievement in recent years. The analysis of the data reported here begin to document the contributions this aspect of the partnership to the quality of health care delivered at Kaiser Permanente. This is all the more important given the growing body of evidence that well coordinated teams can have significant affects on the quality of health care and that their use is growing in many health care organizations.\(^6\) While we lack the data needed to compare the number and performance of UBTs at Kaiser Permanente to those in other organizations, I believe it is safe to say that Kaiser Permanente is ahead of most, if not all, its competitors in the number and perhaps the effectiveness of front line teams.

**2010 and 2012 Contract Negotiations**

In 2010 KP and the Coalition negotiated a new two year contract and in 2012 they negotiated a new three year agreement. As in prior rounds of bargaining both sets of negotiations were proceeded by extensive information exchange and sharing regarding KP’s financial performance and projections, and by engaging large numbers of local union delegates in pre-bargaining conversations. Interest based negotiations techniques were used in both years. The pool of union representatives involved in the negotiations process, already large by most standards, was also expanded in 2012. The unions created an observer status and expanded the central bargaining table (what the parties call the Common Issues Committee) to increase opportunities for rank and file involvement.

One union leader who has been in bargaining over the full course of the partnership provided a perspective on the progress made in using this approach.

In 2005, in advance of bargaining the first renewal of the National Agreement the parties first had discussions about whether or not we should renew our commitment to Partnership and continue on the path we started down in 2000. We went through some tense, serious, and honest conversations and agreed to continue on in Partnership. We then went on to bargain a successful renewal.

In 2012 the parties simply came together and began the frank and open discussions that resulted in the next National Agreement. The difference was that the value of our Partnership was clear and unquestioned in 2012. The trust was there and the parties fully understood the value that had. This could not have happened in 2005.

Both agreements received very high levels of approval by union members. The 2010 agreement was ratified by a 95 percent vote; the 2012 contract received a 85 percent ratification vote.

Retiree Benefits. A major debate within management (and with union leaders) occurred in 2010 negotiations over whether to address KP’s growing concerns over future pension and retiree health care liabilities. Eventually the parties decided to put those issues aside with a commitment to address them in 2012 negotiations.

The parties focused directly on the retiree health care issue in 2012 negotiations. A benefits subcommittee was charged with exploring options and seeking consensus on possible changes in retiree health care. Management was clear about its interests: Get control over future cost projections by reducing its open ended responsibilities and thereby lowering the amount it needed to set aside to cover future liabilities. The Coalition was equally clear about its key interests: No cuts in benefits. The benefits’ subcommittee used these two interests to explore options and ended with an agreement that achieved both. The agreement reached via the subcommittee and accepted by the Common Interest Committee essentially capped KP’s future liabilities for retiree health care costs by agreeing that employees would absorb cost increases if the overall rate of health care costs rises above a threshold amount. This cap is scheduled to take effect in 2017 although the cap and all other aspects of the retiree health care program and funding are open for further review and potential change in 2015 contract negotiations.

Having a cap in place gives KP’s actuaries the ability to predict its future costs with greater certainty and less money needs to be set aside each year to cover these future costs. Most of the parties that participated directly in the negotiations over this complex set of issues described it as a good example of the use of interest-based bargaining.

Some within management describe the results as “outstanding” and some describe them as “a very important first step” in efforts to curb what had been viewed as unsustainable future increases.

How did it all come out? Fantastic. Our objective was to reduce our liabilities; theirs was to not change any benefits and we achieved both. We made no change in the current contract but we got changes in our accounting credits/ liabilities we needed to reduce our expenses.

The 2012 collective bargaining agreement was a big achievement. We began to address post retirement liabilities—emphasis on the “began.” It is never easy to discuss this but labor showed a willingness to come to the table on this with an open frame of mind and a commitment to dig in and see what might be possible. That was a real achievement. We have more to do down the road.
Thus 2015 bargaining will be pivotal. KP management clearly sees the need to make further reforms to lower the long term costs and accounting liabilities associated with retiree health care and, at some point in the future, to also make changes to lower future liabilities associated with the defined benefit pension plan. Coalition union leaders will have difficulty agreeing to further changes unless the changes they agreed to in 2012 negotiations are also applied to non-coalition unions currently in negotiations or, as is the case with the CNA, when its contract is renegotiated in 2014. KP has negotiated benefit changes with other non-partner, non-CNA unions during the 2012 and 2013 period. Non coalition union leaders are strongly opposed to accepting reductions in retiree health care benefits. Thus, how the parties address these retiree health and pension issues in the next three years will serve as another pivotal event for the partnership.

**Total Health**

Another key feature of the 2012 negotiations and agreement was the emphasis given to promoting a healthy workforce. This too was a keen interest of management. The Coalition shared this interest but was equally keen on not designing a program that included incentives or penalties applying to *individual* members (e.g., bonuses to individuals who stop smoking or lose weight). The result, labeled “Total Health,” is a range of joint education and other programs to promote workforce awareness and wellness along with incentives that will trigger bonuses if certain targets are met *collectively*. Figure 13 summarizes the key Total Health provisions included in the agreement. To my knowledge, this represents the most elaborate set of contract and/or joint union-management provisions on this subject in the country. Further, it is likely to get organizational attention and support in that it is tied into a KP business strategy of improving the health of their insurance customers’ workers. Total Health within KP is intended to provide a model for those customers. One of the union leaders put it this way:

*America, California, everywhere, we are struggling to control epidemic increases in chronic diseases that drive 80-85% of health care—obesity, diabetes, etc. KP members are not any healthier than the general population so we have to come to terms as model deliverers and model consumers of health care. So in last round of bargaining we agreed to “total health” conditions and what is neat about it is we will create a system where if a workforce as the whole improves, the full group will share in a bonus. KP’s business strategy is total care—that’s the whole integrated model and we now engage our workforce in this and led by unionized workers… Workers get it.*

A management representative liked the way that union leader put this issue in negotiations.

*[One Union leader] in particular expressed the issue about a healthy workforce in a very relevant way… If more people are diabetic and obese and we don’t do anything about it every dollar will get sucked into paying for this and nothing left for putting it into the paycheck. I would never have framed it that way as a public health professional and so I of course am thrilled…..there is an opportunity to tackle this and [he] is right.*

At the same time, this new approach, like many other initiatives first introduced by the partnership, carries some risks and critiques. Some union delegates reacted negatively to this aspect of the new contract, feeling the program will represent an intrusion into their private lives. The NUHW in particular expressed this view in its critique of the program,, as expressed in a flyer that said:

*SEIU wants us to “peer pressure” our co-workers into...*
making the personal lifestyle choices that management wants us to make so that KP can pay out less money for our health coverage. What kind of union tries to make its members police their co-workers to help management increase their profits?

Our personal lifestyles are none of SEIU’s business. We’re adults, and we shouldn’t be punished for making our own decisions about our lives.

Source:  http://nuhw.squarespace.com/storage/doc/leaflets/Pee%20Pressure.pdf

New programs like this are not self-implementing. Generating concrete results and workforce acceptance will require strong joint leadership and follow-through by union and management representatives at the national, regional, and worksite levels. It will be especially important to implement the new program quickly in order to track and document its effects and the reactions of the workforce prior to the next round of contract negotiations. If this approach to total health is successful it may well serve as a model for other employers and unions in the country.

Figure 13:  Total Health Provisions in 2012 National Agreement

Total Health Provisions in 2012 National Agreement

The parties share the goal of creating the healthiest workforce in the health care industry by improving the quality and length of employees’ lives and enhancing the effectiveness and productivity of the organization. To achieve this vision, the LMP strategy group shall empower a program-wide leadership group, the Total Health Leadership Committee, of appropriate representatives of the Coalition and KP to oversee and implement all of the work associated with creating a comprehensive Total Health program for KP employees.

The committee shall endeavor to create a Total Health Program Incentive (“THPI”) separate and apart from the Performance Sharing Program, which shall seek to encourage employees to collectively: (1) Update biometric risk screenings; (2) Complete the Total Health Assessment; (3) Maintain or make steady improvements on key biometric risks (weight, smoking, blood pressure and cholesterol).

The THPI shall be developed in accordance with the principles of the Partnership, and shall be premised on the proposition that an incentive is only paid out if there are mutually agreed-upon savings in health care costs as the result of measurable improvements of the biometric risk indicators; or if the parties mutually agree that significant progress has been made toward desired outcomes.
Inter-Union Battles and Other Conflicts

SEIU and NUHW. In January 2009, the SEIU placed the California local union with 50,000 KP members in trusteeship for alleged mismanagement of union funds. In response to the trusteeship and being removed from their leadership positions, Rosselli and a number of his fellow officers resigned from SEIU, started building NUHW, and began efforts to convince KP workers to switch to this new union. Union petitions for elections to represent these workers were filed and although NUHW failed to win an election with the large state-wide unit, it did win representation rights in three smaller units.

The NUHW also challenged the legality of the state-wide election outcome by arguing that KP management indicated the pay raises and performance sharing bonuses negotiated by the Coalition unions in 2008 would not apply to employees who voted to be represented by NUHW and that the SEIU used these statements in its election campaign for the state-wide unit. The NLRB ruled that these actions constituted an unfair labor practice, set aside the results of the statewide election, and ordered that a new election be held.\(^7\)

The second election was held in April 2013. SEIU again prevailed over NUHW by a 58 to 42 percent margin. It remains to be seen if this resolves all the representation questions or if the inter-union conflicts continue. To date, the NUHW has not been able to successfully negotiate contracts with KP and has conducted several one day strikes. Moreover, in January 2013 the NUHW joined the CNA. How this alliance will affect the partnership also remains to be seen.

Sal Rosselli and his fellow officers were strong supporters of the partnership while in office prior to their resignation from SEIU. They were highly instrumental in fostering the interest-based negotiations processes that produced the three national agreements between 2000 and 2008. Rosselli gave this assessment of the partnership in those years:

\[
I\text{ believe the Partnership was the best in our experience in the country; bargaining in 2000 and 2005 were outstanding examples of this. We obtained the best contract in the industry and KP was providing the best care and was viewed as a best place to work. The fundamental reason for those successes was there was an appropriate balance of power between labor and management. }
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In his view, however, conditions have changed dramatically in recent years.

\[
\text{Now it got turned totally on its head. [The current union leaders] have totally bought into the employer’s agenda unchecked; they do only what KP wants; the current contract has not been enforced since the trusteeship. The way the union leaders have allowed the collective bargaining agreement to be interpreted has given Kaiser Permanente all the flexibility they want anytime they want it.}
\]

Some rank and file employees are also critical of the partnership. One who had been active in national negotiations for several contracts, included 2012, was particularly disillusioned with current representation.

\[
\text{Everything was already done—a back door deal. Every time one of the rank and file wanted to do things there would be big push back. As long as we would go along with their program they were fine with that but otherwise we got lots of pushback.}
\]

In 2010 bargaining one of the big things we heard about was the threat of NUHW—“we better do this or NUHW will come and take the members from the union.”

\[
\text{In 2012 I was an alternate. I did not have a voting seat; I sat on one of the subcommittees. It was the same thing. Those who ran the union had the say so more than us. If we tried to speak up we got told not to say anything}
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\(^7\)See United States of America Before the National Labor Relations Board Division of Judges, Kaiser Foundation Health Plan, Inc. and National Union of Healthcare Workers and SEIU-UHW (Service Employees International Union, United Healthcare Workers-West, Case 32-RC-5775, July 14, 2011.
to the members… So the last couple days they excused us out of the room and we really don’t know what we really gave up.

Partnership? I dismiss it and don’t want to be in it. If partnership means partnership and that would be a good idea. But KP only wants to have a partnership when it works for them. I don’t think we should be used only to make them look good.

The results of the two union elections and the employee survey data that will be presented in Table 1 and discussed below indicate that the views expressed by this union member and the critiques of the partnership expressed by NUHW leaders are not shared by the majority of bargaining unit employees. Both the survey data and the election results suggest that approximately 40 percent give the partnership a “neutral” or “unfavorable” rating or prefer an alternative representative. Thus, while not reflective of the majority, a significant degree of skepticism and some active opposition to the partnership continues within the workforce and from non-partnership union leaders.

Managers’ Reactions to the Inter-Union Conflicts. The on-going inter-union differences and conflicts have been frustrating to KP managers and union leaders who want to continue moving the partnership forward. Several typical comments from management interviews are listed below.

What do I think about the inter-union issues? We have to be neutral and yet we are caught in the middle. On a daily basis we are criticized by both. We are tired of being in the middle.

The fact that we haven’t accomplished getting all of the unions into the coalition means we haven’t created as much full partnership as if we had been able to bring them all in. This really puts us in the middle of or exposed to potential or actual inter-union competition and behavior. It is unfortunate that despite all the work everyone put into it we haven’t gotten all our unions aligned because there is this civil war.

The conflicts between the unions impact operations significantly. NUHW is very difficult to deal with. We have been negotiating for two or three years and still getting nowhere. It is disruptive in the workplace to have skirmishes between the two and it limits the ability of partner unions to be collaborative.

Reversion to More Traditional Labor Relations Practices. The persistence of these inter-union differences, and perhaps other pressures, have led KP management to formalize and tighten some aspects of its labor relations strategy and practices to focus more closely on conforming to traditional doctrines and approaches. As a result, in at least one case, a partnership union likewise resorted to more traditional patterns.

The case involved a dispute between Kaiser Permanente leaders in Southern California and the leaders of the United Nurses Association of California (UNAC) over how to address what managers indicated was a $500 million budget shortfall identified in 2011. Efforts to use interest-based processes to address this crisis failed. A series of more traditional tactics then played out. Management identified a list of people subject to layoffs that did not conform to the seniority provisions in the labor agreement. UNAC indicated the contract provisions governing layoffs needed to be followed. Failure to resolve this disagreement led to picketing, suspension of UNAC partnership activities, and eventually to an agreement to follow the processes prescribed by the contract. While this resolved the specific issue and partnership activities (e.g. participation in UBTs) resumed, the failure of the parties to address this crisis in ways consistent with partnership principles and processes was viewed as a significant setback.
Employee Views of their Work Environment and the Partnership

How have employees reacted to all the events of the past several years—expanded use of teams, on-going inter-union rivalries, contract renewals, etc.? Contract ratifications and union election results provide two indicators of the views of those directly involved in specific bargaining units. Employee surveys provide another.

For the past decade, Kaiser Permanente’s Organizational Research Unit has conducted a periodic “People Pulse” survey of all employees and managers. The surveys cover a standard set of questions measuring employee attitudes toward their work, their influence in decision-making, and their views of the LMP and of Kaiser Permanente as a place to work and to obtain health care. Data are presented in Table 1 on several of these questions and indices that average some of the individual questions in the 2011 survey along with the percentage point changes in responses between the 2009 and 2011 surveys.

The data are categorized by union members covered under partnership and non-partnership unions. The views of members of partnership unions largely either remained the same or increased by one or two percentage points over these years. Further examination of the survey data showed that partnership union members either improved slightly or remained the same on forty-seven out of the fifty-one questions asked in the survey and none declined by more than three percentage points. A lower (but still majority) of members of non-partnership unions gave favorable responses to these questions in both surveys but their views declined slightly (between one and three percentage points between 2009 and 2011 in the items shown in Table 1. Declines were experienced by non-partnership union members in about half (26 out of 51) of the questions asked in the surveys. It should be noted that these data cover all partnership and non-partnership represented union members and therefore should not be viewed as providing a specific comparison of SEIU and NUHW represented workers. It is not possible to break the data down to this level of detail to provide this specific comparison.

As shown in Table 1, the LMP also continues to be viewed as favorable by approximately 60 percent or partnership union members. This rating has not changed significantly since 2009. A number of the questions included in KP’s People Pulse survey replicate those in a national health care survey carried out by Towers Watson, a consulting firm that conducts standardized surveys for client employers in order to provide external industry-specific benchmarks for comparison purposes (Towers Watson WorkUSA Survey). KP’s partnership union employees on average scored 11 percentage points higher when compared to data from employees in all health care firms in Towers Watson’s data base. Partnership union members at KP scored on average between one and two percentage points below data from Towers Watson’s “Best in Class” healthcare employers. Taken together, these data indicate KP employees represented in the partnership rate their work environment considerably higher than the average of other health care employees and are slightly under the benchmark norm for best in class in the industry.
**Management and Labor Leader Views of the Partnership**

The managers and labor leaders interviewed for this report were each asked to indicate the metrics they use to evaluate the partnership and to provide their personal assessments of the partnership against these metrics. Below is a sampling of their responses.

"The metric mentioned most frequently was the level of trust built up over the years among management and labor leaders.

"The essence of the Partnership is trust. And we are fortunate that we have trust at the leadership level.

Another KP executive reviewed how trust evolved over the years and provided specific examples of how it helps the parties address difficult issues in informal and formal ways.

"I'm a proponent of the partnership. I've been involved in all 5 national bargaining teams and work closely with labor parties in ways that are only possible because our relationships is built on trust. I remember the mid 90s when KP was going down the tubes in a tailspin. Out of that crisis the partnership was formed on the realization that the adversarial relationship had to end. Among the objectives we have achieved is the ability of the Partnership to facilitate a constructive relationship with the individual unions and with unionized workforce. By constructive I mean one that allows us to carry out the business of the organization an orderly, efficient, and non-disruptive manner."
A closely related point mentioned by several interviewees is the ability to resolve problems as they arise, either through formal or informal discussions.

I think the partnership is working reasonably well. We can have very honest discussions and get things done. We talk both in formal settings and informally. We have made remarkable progress in the movement toward UBTs and toward a performance culture. In PSP we have agreed on the metrics well before the beginning of the year compared to earlier years when it might take until April. Now we get done by November and have information out to people by January. Last year we had a bit of controversy over an incentive program for flu vaccination. Without a formal mandate for health workers to take the flu shot or wear a mask, we had to structure a less intrusive incentive based approach in our PSP program. There was considerable discussion and we worked out this compromise approach.

There was nearly universal agreement among both management union leaders that the growth and increased effectiveness of UBTs is the partnership’s most important substantive achievement in recent years.

What are our most important achievements since 2010? We have worked well on our IBB problem solving processes in negotiations and on partnering on a daily basis and on building UBTs. We have performed remarkably since then on growth, quality, etc. The partnership has contributed to making us the number one health care quality provider.

UBTs are probably most rigorous in the program right now. Teams are working diligently on making themselves high performing and not just working on minor issues. In terms of quality and service all the work around UBTs has really helped us—our quality and service are really up there—#1 Medicare service in the world—service up as well to 80% on HCAHPS measures. And I actually think it is partnership that has done this—our partnership with the medical group and partnership with the Coalition. Together we have translated partnership to the front lines.

The heart of partnership is on front line with physicians and staff. When they do their work are they doing it collaboratively? LMP has helped that process; employees and staff understand the business part of the business—about KP’s mission, nonprofit status, and integrated delivery system. Partnership has facilitated this. Without partnership this was still possible but would have been more haphazard, and would have taken more effort.

Union leaders shared these assessments but take a somewhat more expansive perspective in evaluating the partnership. One put it this way.

KP employees are the best compensated health care workers in California and arguably in America. These are terrific jobs and America needs millions more jobs like them. But this also makes the partnership a target and we better think long and hard about how to maintain this. To the credit of all who maintain the partnership, KP takes the high road. Kaiser Permanente and the unions have chosen to pursue a business strategy that wants to deliver great care, be the best place to work and pay the best wages and benefits. The whole value compass is taken seriously. KP is top notch in care delivered, in terms of any outcome you want to look at. It is nice to see that the best health care in America is given by the highest compensated and highest unionized labor force. This is a case where the industry leader is also the best labor management relationship in America.

Another union leader reflected back to the aspiration of the founders of the partnership.

I would start by saying that we are now in a place where those who began this process in 1997 and 1998 would be pleased. I am guessing that their aspiration was for us to be something extraordinary where leaders from both sides could sit in a room and work together to solve common problems as partners, not adversaries. To a large extent I believe we have achieved that. Perhaps the leaders for 1998 would have hoped that we had gotten here sooner than this but we have come a long way together. Partnership is no longer something we consider doing, it is now how we conduct our business every day.

When asked about their disappointments since 2009, various interviewees noted significant concerns with the pace of change, accountability of the parties,
and the limited ability to address affordability and other tough issues.

The partnership is moving in the right direction, but at the speed we need, no. I also don’t think we have fully grappled with affordability—a serious issue as I look at what’s coming with health care reform. What worries me is that we’ll be asked to take care of lot more people with lot less revenue per member. So resources will be really challenged and volumes will be significant. This will drive us to figure out how to deliver care more efficiently.

We have to be focused on affordability; and we haven’t always put this at the forefront. A clinicians’ point of view is normally to focus on patient care and quality. That’s important but more and more the jolt the economy took these past years and the changing reimbursement situation now make affordability a key concept.

Another executive put the pace of change in concrete dollars and cents terms.

The fact that we live in a unionized environment has made some changes in administrative work more slow and expensive. For example, we opened two new contact centers to answer phone calls in California. The new ones are well developed and so we closed down older ones and because of the partnership it took another year and half and another $20 million, more than any of our competitors would have done. The extensive security provisions of the agreement that are awfully good for the workers have added costs and slowed down pace and also materially constrained the aggressive pursuit of more efficient ways of doing things. If it didn’t take a couple years and tens of millions to get things done we would have more ideas of how to take costs out of the administrative side. So the LMP doesn’t prohibit doing things that are highly efficient but it takes longer and costs more and so that reduces the number of things that can be considered.

Another executive with extensive experience with the partnership was more critical.

I’d characterize my reaction to the partnership as largely disappointed. Management hasn’t held labor accountable for behaving as partners and has allowed the coalition to not function as a coalition; it is management’s fault for not holding them to this standard. For example, when we opened a new facility two different unions divided up the jobs and they can’t fill in for each other. This increases the complexity of managing and increases inefficiencies. It doesn’t speak to there being a coalition. We haven’t figured out a great way to resolve those issues.

One Permanente executive summed up a view expressed in other interviews, and in interviews conducted in our earlier research by saying that support for the partnership continues to be stronger at high leadership levels than among front line management and physician leaders.

The Physician leadership sees value in the partnership. When I think about success for Kaiser Permanente, it would be reflected in how are we working with patients and members to deliver on the KP promise. If our performance is high in access, patient satisfaction, quality and affordability, it demonstrates the success of the organization and our partnership has helped with this.

Do front line physicians share this view? Physicians as a whole are a funny phenomenon; they have a jaded view of the partnership. But if you talk about how they work with their nurses and teams, they love them because physicians are all about process improvements. Where they get jaded it is about attendance. They don’t see any improvement on this. Seniority is also still an issue for them and that hasn’t changed.

Front line managers roll their eyes as well but it is more around the feeling that when they have partnership meetings a lot of work still falls on the manager. There is not joint accountability. Not all the labor people show up as partners at the meetings so accountability is not always there on the labor side. We have some great ones but it is the variability that is a problem.

The need for more “flexibility,” also came up often in management interviews:

Another issue that still comes up is flexibility. Some was negotiated in the 2012 contract but it is still hard to do in practice.
When asked about the future of the partnership, the dominant theme was cautious optimism, checkered with worries about whether KP is up to the challenge of transforming health care delivery given the changes that lie ahead and about the on-going effects of inter-union rivalries.

We are still put together to be incredible leaders on all this—we have 60 years experience; the investments in technology are there to give us the chance to transform healthcare. The question is can we embrace this opportunity and do we have the relationships needed to work on this.

I have a reasonable degree of confidence we can do it but the coalition is not a firm coalition—it is a disparate mix of unions and the inter- and intra-union politics sometime raise havoc. So labor has to get it together!

Union leaders are also optimistic but share some of the same worries about the ability to adapt to the changes that lie ahead.

Do we want to turn KP into GM and do we want to be the UAW? We have talked about this. What keeps me up at night is, how do we get those in their 40s and 50s to retirement age with all they are expecting. I don’t want to be around while we have lost defined benefit pensions or retiree health care. But we are getting into a much more volatile period for health care. The trick going forward is that we are completely committed to staying on the high road. That doesn’t mean we can be for the status quo. So what can we do before we become victims of our own success?

Incoming KP CEO Bernard Tyson summed up his view in a video on the partnership:

We have tapped into the potential of smart people. They come in here every day to ask how do I improve quality, how do I improve service, how do I improve affordability. That is incredible strength and a competitive advantage for our organization…. There have been times at which we have had total disagreement. What’s been great is we don’t walk away from it; we don’t say well you are not a partner and let’s go to plan B. There is no plan B. The commitment is to partnership.8

National Health Care Policy and its Effects

The U.S. enacted a national health insurance law in 2010 (the Affordable Care Act) that, when more fully implemented in 2014, will extend coverage to most of the population. The new law poses both tremendous opportunities and challenges to KP and the labor management partnership. The opportunities lie in the large new pool of potential customers that KP can compete for—essentially a pool of lower income individuals and families. One early estimate made before specific bids were made for any of the potential new customers suggested that KP could potentially grow by 200,000 members in Southern California alone. (This may, however, have been too optimistic given that KP’s initial bids for “Exchange” customers, i.e., those not covered under Medicare, Medicaid or an employer health care plan, came in higher than some of its competitors). The payment provisions in the law will very likely put enormous downward pressure on prices for health care coverage, both for the new low income enrollees and for those over the age of 65 covered by the nation’s Medicare program. KP cannot hope to compete for these groups without substantially lowering the price of its insurance offerings and services. One estimate is that the revenue per patient for Medicaid enrollees may be as much as 40 percent less than KP’s average per-patient revenue. Those covered through the law’s Exchange option will be somewhere between this 40 percent lower rate and KP’s current average per patient revenue.

There is widespread awareness of these challenges. Typical comments from interviewees include:

The health care law puts a bit of a strain on all of us and challenges us in terms of our cost structure. With

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revenue being cut and with our high fixed costs and high labor rates it will really force us to figure out how to fix our cost structure and with lots of competitors beginning to look more like us without all the costs we have. Lots of consolidation of hospitals and medical groups is going on. So my worry is, do we have the flexibility to navigate and change our cost structure?

A union representative put it this way.

There will be disruptive change. KP has been slow to provide care to the Medicaid population. The unions will not be an impediment to providing this care. Care is moving away from old systems to new business models—supplemental and parallel to KP’s model. But we can’t cost shift (shifting costs to workers) way out of this problem. California is at the bottom of the Medicaid system in terms of payment levels. So there has to be national Medicaid reform; 17 million people will get covered through Medicaid expansion and 4 million in Cal. So this has to be assimilated and we can’t do it if we are losing 40 to 60 cents on the dollar. Reform has to be part of the process; but we will be taken seriously only if we are model care givers and doing everything we can to be nimble in constructing teams to deliver quality care… not just at KP but in all of the health care industry.

Another union leader put the challenges in perspective of prior cost crises.

Obviously we have cost and competition concerns in the advent of the new health care act. I do however feel confident that we can work through issues that arise. In 2007 we faced challenges over getting costs down and we successfully worked through those issues. Our management partners shared their concerns and provided data, and together we came up with a combination of incentives and agreements which allowed some positions that were no longer needed to be eliminated and employees to benefit from early retirement and other options. We were able to work together to find solutions that would work for both sides and not simply bargain from defensive positions.”

As the data presented above attest, the partnership has done a good job at helping KP achieve incremental changes in practices that gradually improve service and quality outcomes and employee views of KP as a place to work and to receive medical care. The new price points for these growth opportunities will, however, likely require radical or disruptive changes to lower costs that cannot be achieved with marginal or incremental changes in practices. Whether and how KP and the partnership address the demand for disruptive change will be among the next big challenges the parties face.

How might the partnership tackle this enormous challenge? It is clear that the cost gaps cannot be closed simply by cutting wages and benefits. Nor will solutions likely come from marginal changes in work rules that provide greater flexibility to adjust staffing patterns, something that many managers see as essential in its own right. Some means of exploring and testing more “radical” or “disruptive” approaches to organizing health care delivery for these populations and perhaps for others will need to be pursued.

Consensus Features of Emerging Health Care Models

To provide a context for the types of changes that will be needed, it may be helpful to summarize how health care experts, at KP and nationwide, see the delivery of health care evolving in the years ahead. The key features of the emerging model include:

1. The importance of data and information networks: Extensive use of technology, patient health data, and evidence-based treatment protocols to support preventive health care, determine treatment options, and monitor patients (including self-monitoring);

(2) Remote Care: Less reliance on patient visits to clinics or hospital stays and more reliance on home care, community-based care, self monitoring, staff monitoring of patient panels and communications via email or phone, and;

(3) Team Based Models: Movement from physician centered care models to ones that rely more heavily on well coordinated teams of physicians, nurse practitioners, nurses, other staff, community liaisons, patients, and their family or other personal caregivers.

KP executive, physician, and union leaders recognize the centrality of these features.

We have to break into the information age of health care. Tens of thousands of double blind experimental studies are coming out and all this knowledge is available on the web. The explosion of knowledge means physicians are no longer at the center of patient care. The key is using information smartly and using health care teams that can manage the health care process—teams of pharmacists, techs, nurses, physicians, specialists, etc. working within their scope of practice and using a team based approach.

Digital, social media and information technology will put lot of pressure on the partnership to make better use of these tools (information technology) to get the results we want. Fundamental changes in time and spatial dimensions of health care delivery are possible. Patient-caregiver interactions are no longer confined to face to face or physical visits. They are no longer related to point in time or geography. This requires a different and more nimble workforce. We will not need as many offices but on the other hand we will need more people out in the home and community doing work a doctor doesn’t have to do to find patients, educate them, get them to comply with their treatment plans and so on. We are just on the edge of this change. The partnership will have to help us navigate these changes.

I see adoption of the features in this new model as the biggest challenge and the biggest opportunity facing the partnership. For that reason I present ideas for addressing this issue in the final section of this report.

CONCLUSIONS

The partnership built by Kaiser Permanente and the union Coalition has now survived for fifteen years and continues to serve as the nation’s largest and most comprehensive labor management partnership in history. While labor-management partnerships tend to have limited half-lives, this one has demonstrated an ability to work through the various pivotal events that come along and often lead to their demise. Over its first decade, the partnership helped turn around Kaiser Permanente’s financial performance, built and sustained a record of labor peace and demonstrated the value of using interest based processes to negotiate national labor agreements and to resolve problems on a day-to-day basis. In the past five years the parties have achieved significant progress in integrating the partnership into the standard operating model for delivering health care by engaging teams of employees, supervisors, and physicians in team-based continuous improvement processes. As a result, Kaiser Permanente is now one of the nation’s leaders in the use of front line teams to improve health care delivery. Combining negotiation of a comprehensive employment security agreement and protocols for managing technological change with direct engagement of employees and union representatives in the implementation of new technologies and ways of working has helped to also make Kaiser Permanente a national leader in the use of electronic medical records. The evidence from our research and multiple other studies demonstrates the payoffs of this integration of technology and work process innovations to the

10See Adam Seth Litwin “Technological Change at Work: The Impact of Employee Involvement on the Effectiveness of Health Information Technology,” Industrial and Labor Relations Review, 64, 5, October, 2011, 863-889. This study is based on Kaiser Permanente data.
quality of health care KP delivers. Yet challenges remain. The most obvious challenges will involve addressing concerns about affordability, flexibility, better documentation of the benefits of partnership, and managing through leadership transitions and coping with the effects of continuing inter-union conflicts. I offer suggestions for how these issues might be addressed in the final section below.

RECOMMENDATIONS

The partnership will continue to be tested in the future as it has been periodically over the first decade and a half of its existence. LMP leaders have managed through these “pivotal events” in the past by using the tools of the partnership—information sharing, education, broad-based engagement, joint analysis, problem solving, and constructive negotiations. In doing so, the partnership has been strengthened and broadened by the experiences of those involved. In this final section I will review what I see as the most critical pivotal events on the horizon and ways these partnership tools can be put to use in addressing them.

Experimentation with New Models of Care Delivery

I begin with discussion of the greatest challenge but also the greatest opportunity facing the partnership, and indeed, facing Kaiser Permanente and most other health care delivery organizations. Labor and management leaders at KP fully understand the challenges that lie ahead as the provisions of the Affordable Care Act come into place and more generally as the health care industry enters an era where improving affordability will be the primary driving force. Meeting the challenge will require complementing (not replacing) the steady incremental improvement strategies and practices that have been the signature achievement of the partnership up to this point with strategies capable of introducing radical or disruptive innovations in health care delivery. A number of pilot projects and experiments of this kind are underway within specific regions. Many of these involve expanded use of telemedicine and other technology-focused innovations for communicating with patients in their homes, places of work, or retail centers. KP’s Innovation Fund for Technology has seeded over 80 such experiments and about 17 of them are now operational. Others are testing use of inter-disciplinary teams for home care and partnering with community health centers. Still others involve full blown simulations and experiments carried out at Kaiser Permanente’s Sydney R. Garfield Health Care Innovation Center. Kaiser Permanente is also a member of an international Innovation Learning Network in which peer healthcare delivery organizations share best practices and discuss ideas for further innovation.

At this point there is no full inventory of these pilots and experiments. Moreover, to date few have been shared across regions or discussed with or among LMP leaders. Putting a shared learning process in place with support from the highest levels of Kaiser Permanente and the union Coalition should be a very high priority.

There is a model for doing so that might be considered. In the early 1980s General Motors (GM) and the United Auto Workers Union (UAW) recognized that they could not build a small car competitively in the US given the GM organizational structures, management systems, and labor management practices and contract provisions. Given this, they created what came to be known as the “Committee of 99”—a cross section of managers, engineers, accountants, supervisors, union leaders and stewards, and rank and file employees—and charged it with the task of benchmarking the best practices in manufacturing, organization design, and employee relations. The result: The parties created Saturn using the slogan of “a new kind of company and a new kind of car.” The “radical” innovations embodied in Saturn included a full labor management partnership from top to bottom of the orga-
nization, recruitment of volunteer GM employees and union members interested in working in the new organization, a team based work system with a minimum of job classifications, and UAW level wages and benefits earned through a combination of standard hourly wage rates and gain-sharing based on specific performance targets. Instead of the several hundred page long contract governing traditional GM-UAW workplaces, the parties wrote a simplified 28 page labor agreement.

Saturn performed well throughout the product life cycle of its initial models but then floundered after its champions in GM and the UAW retired. By then Saturn had become isolated from and resented by management and union leaders in other parts of GM and the UAW. The new generation of top leaders in either GM or the parent UAW did not share the founders’ vision for Saturn failed to allocate new products in time to keep Saturn competitive.¹¹

I believe the Saturn experience offers clear lessons for how the labor-management partnership at Kaiser Permanente might address its transformative challenge. Specifically, I propose the top Kaiser Permanente and Coalition leaders create and sponsor a national-level and/or regional level working groups and charge them with the task of taking a clean sheet of paper approach to the design and delivery of health care for the new target populations KP wishes to serve. The national working group could start by benchmarking the best health care practices and models it can find inside and outside of KP and proposing how KP can learn from these cases. Based on the lessons learned more controlled experiments could be designed to test and learn from experiences with the new models. In doing so care should be taken to build an evidence-based, organizational learning process that avoids two pitfalls experienced by Saturn and many other “greenfield” organizations: (1) getting isolated, discounted, and resented by leaders in other part of the organization and thereby closed to learning from the experiences of the new model, and (2) getting abandoned by successor leaders who have no personal identification with or ownership of models initiated by their predecessors.

Data Analysis

“Big data” is a current buzzword in health care and elsewhere. Kaiser Permanente has been a leader in using data extensively to support improvements in health care. It also collects an enormous amount of data on health care quality, cost, service, financial performance and return on capital. And, as noted throughout this report, it collects an equally impressive amount of data on workforce attitudes, team processes, and outcomes. Only recently, however, have these different bodies of data been combined in ways that allow assessments of the effects of its investments in labor management partnership processes. And these recent efforts have proven difficult to carry out because of KP’s longstanding traditions of allowing each region to control collection and use of its data. Moreover, the research groups carrying out analysis of the various data sets collected by Kaiser Permanente are relatively specialized and have not fully exploited the potential of joint analysis data on use of technology, patient outcomes, workforce, engagement, team processes, and other partnership initiatives. Therefore, I suggest that leaders of Kaiser Permanente and the union Coalition create a cross sectional “Big Data” working group to carry out and widely disseminate within and outside of Kaiser Permanente analyses that utilize the data available to assess the costs and benefits of working in partnership, using advanced technology, and engaging the workforce in improving the quality and affordability of health care and providing good jobs and careers. This group should also be charged with recommending, where necessary, changes in data collection and sharing protocols needed to better utilize data to support

and assess health care delivery on a system-wide basis. Given the importance of these issues to the nation, the work of this group should be published and disseminated as widely as possible.

**Leadership Transitions**

Leadership transitions are a normal part of organizational life. But they have proven to be points of significant vulnerability to labor management partnerships (and other forms of organizational innovation sponsored or identified with outgoing leaders). This is true not only of leadership transitions at the top but also of promotions, elections, or assignments of leaders at all organizational levels.

A new CEO, Bernard Tyson, is now taking office at Kaiser Permanente and many senior executives at KP are relatively new to the partnership. Likewise, a new Executive Director of the Coalition of Kaiser Permanente Unions will soon be chosen since John August has recently retired from this position.

One way to promote continuity through leadership transitions is to ask how candidates for future positions would engage the partnership principles and processes in the recruitment or election process and weigh their capacity to do so in the decision process, educate incumbents in the types of “distributed” or “shared” leadership processes best suited to support partnerships, and hold them accountable for following through once in their positions. This could be supported by conducting an on-going seminar for new leaders that both educates them on how the partnership works and strengthens their leadership skills. For maximum effect these seminars should include a broad mix of newly appointed or elected managers, executives, physician leaders, and union leaders from all organizational levels.

**Inter-union Conflicts and Rivalries**

Finally, rivalries and conflicts between partnership unions and non-partnership unions continue to complicate labor relations and partnership activities. Workers have now voted twice to continue to be represented by SEIU. Given these results, it is time to put the issue of representation of these workers to rest. Rivalries and differences in philosophies continue, however, between the CNA representing nurses in Northern California and partnership unions. The partnership has continued to grow and strengthen through the years of these inter-union conflicts and should be able to continue to do so given the strong stated commitment to the partnership expressed by both senior Kaiser Permanente executives and Coalition union leaders. However, should these inter-union tensions intensify, top level leaders from the highest levels of the AFL-CIO and the Change to Win Federation may need to once again help the unions involved to resolve or manage their differences in ways that do not jeopardize the work of the partnership.

Why should top level labor leaders take an active interest in these issues? Very simply, resolving these representation questions and associated inter-union conflicts is as important to the labor movement as it is to Kaiser Permanente and its workforce. This partnership is the most visible and arguably the most positive labor management relationship in the country, one that labor leaders often promote as illustrating what is possible when management works constructively with labor. Given this, national labor leaders have a deep interest in resolving these conflicts and eliminating potential threats to the partnership. This would not be an unprecedented move. Top level labor leaders have helped resolve similar disputes before, both within the KP coalition and in other settings. They may need to do so again.
The Kaiser Permanente Labor Management Partnership continues to serve as the nation’s largest and most successful labor management partnership in the country. As such it demonstrates the potential value of this approach for both labor relations in the 21st century and as a model for health care delivery and improvement. The signature achievement of the partnership in the past five years has been to create, empower, and sustain worker-led teams in more than 3,500 departments across Kaiser Permanente’s vast organization. The experiences and demonstrated successes of these teams provide a solid base for the parties to now experiment with and implement the new emerging models of care delivery that will shape the future of this industry.

A signature feature of the partnership over the first fifteen years has been its ability to directly confront crises or challenges by putting the tools of the partnership to work in addressing problems as they arise. Undoubtedly, other challenges and crises not discussed above and unforeseen at the moment will arise requiring the same determination, leadership, and skill for the partnership to continue, deepen, and broaden its contribution to the future of health care delivery in America. The stakes involved here are important to Kaiser Permanente, its patients, and its workforce. But they are also important to the future of health care and to the future of worker voice and representation in America. Indeed, the country is watching and eager to continue learning from this critical experiment.