

# **THE LABOR MANAGEMENT PARTNERSHIP AT BALDWIN PARK**



I W E R

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This report is part of a larger on-going study of the evolution of the Labor Management Partnership between Kaiser Permanente and the Coalition of Kaiser Permanente Unions. All reports on this work are available on this website. Support for this work is provided by the Labor Management Trust Fund. All views expressed here are solely those of the author.

## **I. Introduction**

This case study is part of a research project analyzing the evolution of the Kaiser Permanente Labor Management Partnership from 2002 through 2004.<sup>1</sup> The project's first report described the Partnership's initial five years, including its successful initiative to open the Hospital at the Baldwin Park Medical Center (BPMC), which launched the Partnership at Baldwin Park.<sup>2</sup> This study reports on follow-up field research conducted in 2004 at Baldwin Park, including on-site and telephone interviews with management, union officials and facilitators, document and data review, and observing Partnership meetings (Steering Committee and Department Based Teams where rank and file workers, physicians and middle level managers participated). It takes a look at the readiness, capacity, engagement and results that Partnership activities have generated, consistent with the research model constructed for the overall project (*see Appendix A*).

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<sup>1</sup> Thomas Kochan, Robert McKersie, Adrienne Eaton, Paul Adler, Phyllis Segal, Paul Gerhart, The Labor Management Partnership at Kaiser Permanente: 2002-2004 (work in progress). This research is funded by the Kaiser Permanente Labor Management Partnership Trust Fund.

<sup>2</sup> Susan Eaton, Thomas Kochan and Robert McKersie, The Kaiser Permanente Labor Management Partnership: The First Five Years, MIT Institute for Work and Employment Research, 2003.

## **II. Background: Context and Motivating Forces**

The Baldwin Park Medical Center is in Kaiser Permanente's (KP) Southern California Tri-Central Service Area. In addition to the medical offices and hospital in Baldwin Park, the Medical Center has several satellite medical offices, including facilities located in West Covina and Montebello. Approximately 3,500 men and women work at BPMC, including 2,500 organized in collective bargaining units represented by SEIU Local 399, SEIU Local 535, UNAC/UHCP, UFCW Local 1428 and UFCW Local 770.

The Partnership was launched at BPMC soon after the 1997 KP Labor Management Partnership Agreement was signed, when a joint labor management project was created to open the Baldwin Park Hospital (which had been built as a shell a decade earlier, when the BPMC outpatient medical offices were opened). KP determined in late 1997 that financial reasons compelled opening the hospital before the end of the following year, and it was decided to do this as a Partnership activity. A small joint leadership team was formed including key institutional union and KP executives. In addition to this top level leadership, more than 150 doctors, union stewards, managers, nurses, technicians and other staff at all levels participated in subcommittees and an intense blitz week. Since the hospital was not yet staffed, these participants came from other Medical Centers and the BPMC outpatient offices. As reported in the first report, the unions were brought into "*decision-making in areas where they never previously had any say,*" including the design of patient services, mapping process flow, and staffing decisions.

This joint labor management project produced one tangible, and widely showcased, outcome: the BPMC hospital opened in a record-breaking eight months, under budget, with an innovative "patient-centered" design. Two by-products were less tangible, though significant for the future of the Partnership at BPMC. First, the successful experience motivated key leadership to build and sustain an effective Partnership at BPMC, overcoming problems as they developed. Second, the high profile launch set high expectations for this Partnership, creating a challenge going forward.

With respect to the first, the blitz week and other joint work convinced key BPMC management -- including individuals who initially resisted the concept -- of the value of working in a collaborative labor-management relationship. Many of the Partnership leaders at BPMC today participated in the hospital launch. On the management side, for example, Medical Center Administrator Rick Rosoff, who is seen by labor as a champion, describes the "*power of joint accountability, pride of work, results*" in the blitz week experience. The Medical Director described in the earlier case study as an obstacle to the Partnership was succeeded in 2002 by Dr. John Bigley, who participated in the 1998 blitz week when he was Chief of Internal Medicine. Dr. Bigley, described by one local BPMC union member as "*vocal about support for labor management partnership,*"

credits his 1998 experience as showing him how labor management collaboration adds value to the operation of BPMC. Similarly, on the labor side, many of today's BPMC Partnership leaders were involved in the blitz week, including Shirlee Shirley (SEIU Local 399), Jacqueline Asfall (UNAC/UHCP) and Susan Gandy (SEIU Local 535).

With respect to the challenge of "high expectations," the clear common purpose, sense of urgency and deadline for opening the new hospital, with regional and national KP leadership attentive and involved, is quite different from building a relationship that works through day-to-day operational needs. As one of the doctors who participated in the blitz week commented "*When you are doing something innovative you cannot let your enthusiasm decrease because the gains are not as easy as they were when you opened. We are now at the harder part. We have to now integrate the people in decision-making that will yield positive results.*" This was echoed a few years later by Dr. Bigley: "*We opened the hospital at its best, with everyone aligned. Maintaining this is hard.*" Dr. Bigley would like to "*see more energy in the relationship,*" and identifies the need to "*make partnership relevant to this generation.*"

### **III. Process of Change: Readiness, Engagement and Capacity**

The joint consensus decision-making utilized in designing, staffing and opening the hospital bumped against real difficulties once the facility came on line in 1999. Co- team leaders, one from management and one from labor, were designated in some inpatient units to jointly lead the day-to-day activities of running the units, including hiring, firing, scheduling. According to one participant, looking back at this period, *“this did not work out at all, in fact it failed miserably.”*

The extent to which the co-leaders actually shared management responsibility and authority is not clear. In addition, there is some indication that “failure” was not necessarily universal. One person recruited to be a labor co-leader, who came to BPMC with previous management experience, described how she and her management partner worked together on the day-to-day activities of running an adult inpatient unit. Although she recalls this period as stressful, her view is that it was working pretty well. However, the actual shape, extent, and effectiveness of this effort at co-management is less important today than the widely held view that co-management was tried and failed at BPMC

The reason co-management did not work at BPMC is variously attributed to deficiencies in all four “input” elements of the research model – the organizational context, readiness, capacity and engagement. Participants point to insufficient support from high level leadership; inadequate training and skills; unclear roles; overstretched staff; differential pay and authority for the co-leaders; and flawed selection criteria for filling these positions. As the visible committed high-status sponsors outside BPMC shifted their attention to other initiatives and responsibilities, the resources they had brought to the hospital opening, and the sense of urgency, diminished. Newly hired (or transferred) managers and staff working at BPMC were unfamiliar with partnership. Labor “co-managers” had little or no leadership skills or management experience, and training wasn’t part of the plan. As Assistant Medical Center Administrator Sheryl Sack explained, *“We put people from labor into a role expecting them to manage without the skills...No thought about what was needed to develop their skills.”* Weaknesses in communications with workers left Union members seeing their representatives becoming managers rather than taking care of employee interests. Jacqueline Asfall, Labor Liaison from UNAC/UHCP, described how *“A lot of animosity developed among the rank-and-file members. They believed people taking these roles no longer supported labor when they wanted to become managers.”*

In part because the Union co-managers were so new to this, and the experiment was launched with inadequate attention to building capacity, the perception that they were being overly responsive to management was grounded in reality: managers reportedly did have greater influence in the decisions. Since the Union partner’s primary support was his or her co-manager, it was

natural to lean on the management partner. The more this happened, the more the labor partner was seen as becoming part of management. There were no support systems in place to help the labor manager deal with the perception and reality of dual roles – representing labor while partnering in management.

Attempting to create joint management in a new facility, with some staff new to KP and others reassigned from other KP locations, at a time when the national Partnership was just beginning and the BPMC Partnership was first being formed, in effect jumped over foundation building and transitional phases recognized as critical in the “Pathways to Partnership.”<sup>3</sup> These phases were short-circuited as Union members were expected to be immediately integrated into unit decision making.

As “flyers” began to circulate in the hospital urging labor to pull out of the Partnership, one participant described it as “*coming to a roaring halt.*” This pivotal event challenged the continuation of Partnership at BPMC. Looking back at what happened, participants saw this period as a “*critical test for the partnership*” and described how instead of saying “*let’s forget it,*” a small leadership group came together off-line, with a facilitator, to apply issue resolution methodology to understand why it wasn’t working. Through this process: (1) a decision was made to discontinue co-leader joint management in the Hospital (it was never attempted in the Medical Group’s outpatient offices); (2) the BPMC Partnership Steering Committee embarked on a period of reorganizing; (3) the focus shifted from joint decision making and accountability for operations to foundation building; and (4) two full-time labor liaison positions were created – for UNAC/UHCP and Local 399, respectively. These changes are described more fully in the next section. Within a year after the Hospital opened, co-management was over: there were no longer any co-leaders of unit teams, managers were clearly in charge of managing, and ways were being sought for labor to have input through the BPMC Partnership Steering Committee.

## **A. Joint Problem-Solving to Reshape the Partnership**

The small leadership group that guided the Partnership initiative in 1998 was largely made up of management and union leaders who were not based at BPMC, and did not include front-line managers or local union representatives. The transition to a Steering Committee that could lead Partnership at BPMC went through several iterations. Within a few months after the hospital opened, the Steering Committee was being reshaped into a group with two-components: a 13 person “outer ring and a larger “inner ring” comprised of roughly 20 members. Institutional union leaders, senior KP management, and KP Partnership leadership were in the smaller outer ring – including UNAC/UHCP’s Kathy

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<sup>3</sup> This was a five phase plan developed by the partners to direct and support implementation of the Partnership’s goals. See [The First Five Years](#) report, pages 21-21.

Sackman, Local 399's Dave Bullock, Local 535's Priscilla Kania, KP executives Leslie Margolin and Oliver Goldsmith, and OLMP leaders Pete DiCicco and Margaret Piesert. Conceptually, they would be kept in the information loop and attend meetings when possible, though one person involved at the time describes the control in fact retained by the outer ring members as leaving the inner ring without the ability to succeed. Union representatives and senior management who worked at BPMC were in the inner ring. The authority of the inner ring to make decisions without outer ring approval (or second guessing) was uncertain.

The unwieldy size, unclear lines of authority between the inner and outer rings, and absence of front line managers, proved unworkable. Within a year, the Steering Committee underwent another set of changes. It was sharply reduced in size to 12 members, adding, for the first time, unit management. The outer ring was eliminated entirely, as all leadership was transitioned to BPMC-based managers and union representatives. By mid-2001 the BPMC Partnership was in the process of implementing a structure that included tri-chairs (one each from management, UNAC/UHCP and SEIU Local 399), subcommittees (for example, Performance Targets & Measures, Education and Training, Communication), and some informal partnership meetings at the work unit level.

Today, the Steering Committee has grown in size to 20 members – though still smaller than when it was launched -- with the additional membership primarily drawn from unit managers and local labor representatives. UNAC/UHCP, Local 399 and Local 535 each have “Buddy” members on the Steering Committee – who are being groomed for future Partnership leadership. A Steering Committee labor member, comparing this committee with the one that opened the Hospital, described a “*different hierarchy of control*” with members “*familiar with everyday operations, people challenges.*” The committees initially operating under the BPMC Steering Committee now operate instead only at the Service Area level. Despite the changes, it is interesting to note the continuity in Steering Committee membership. Approximately one-third of the current Steering Committee members were on the original Steering Committee in March 1999 – two from labor, and four from management.

Two full-time Labor Liaison positions were created as a one-year pilot in 2000, with their salaries included in the BPMC budget. The individuals appointed to these positions were chosen by Local 399 and UNAC/UHCP, respectively, and Jacqueline Asfall (for UNAC/UHCP) and Shirlee Shirley (for 399), continued to hold these positions in 2004. Initially, one of the responsibilities of the Labor Liaisons was to serve as tri-chairs (with Assistant Medical Center Administrator Sheryl Sack) of the Steering Committee.

The two Labor Liaisons are the only people at BPMC (management or union) working full-time on partnership activities. In addition, Local 535's Susan Gandy devotes roughly half-time to a *de facto* labor liaison role, with the understanding of the Department of Hematology/Oncology, where she works as a Social Work Case Manager. Commenting on management's commitment to the

Labor Liaison positions, Medical Group Administrator Rosoff describes how management “*resisted the temptation to cut the Labor Liaisons from the budget in ‘04 despite considerable budget pressure to do so.*”

As the Steering Committee’s membership was being reshaped, so was its focus. The emphasis on joint decision making was succeeded by attention to foundation building – in particular to training. The Steering Committee’s focus on foundation building resulted in significant training of union members. In 2001, over 50% of the union partner staff was trained, and training continues to be a Partnership focus today. In 2004, BPMC’s strategic goals (as stated on the BPMC Performance Targets Scorecard) include three explicit “LMP goals” – all about training (stating number of employees per quarter to go through LMP/MAPS, IBPS/CDM/IR and UPR training). Similar training goals also appear on the performance target scorecards of individual departments. The distinctions in the goals stated by different departments indicate that they are tailored to the department’s own needs assessment. For example, one department’s target is 100% staff (including managers) trained in LMP IBPS; another targets 100% training in LMP Orientation and Root Learning MAPS. Medical Group Administrator Rosoff emphasizes that training is not only important for labor: “*management training is essential because Partnership success requires managers being willing to let go.*” He estimates the investment in training through 2003 at \$2m.

By late 2002, an additional foundation-related activity adopted by the Steering Committee was to create forums for labor and management to work together throughout BPMC. This “Department Based Team” initiative, which decentralizes partnership by moving it to the front lines of the Medical Center, is described in the next section.

Beyond this attention to structure and foundation building, a management Steering Committee member describes how the BPMC Partnership is now focusing on “*dealing with day-to-day issues...trying to be sure goals are set and aligned with organizational goals.*” Consistent with this description, Partnership work parallels several of the organizational goals stated in the 2004 BPMC Performance Scorecard, including service, workplace safety, employee attendance and cost saving initiatives. Both service and workplace safety are linked to performance pay, which has created tangible incentives for attention. Some of the Partnership activities in these areas are described below. The BPMC and department performance scorecards don’t identify these targets as “LMP Goals,” as is done with the training targets. One manager points to this as illustrating how Partnership is integrated into the organization – there are no silos that say “LMP.” It also serves, however, to make accountability, and attributing achievements to the Partnership beyond training, less visible.

Local 399 Labor Liaison Shirlee Shirley describes the current Steering Committee as working much better than at the beginning when it was mostly labor asking “*who from labor is involved.*” She describes the culture of the

committee in 2004 as one where management also asks “*what about labor ... who will be your labor partner?*”, and managers throughout BPMC as thinking this way.

## **B. Strengthening Capacity and Driving Engagement Throughout BPMC With Department-Based Teams**

By mid 2002, the Steering Committee was turning its attention to establishing Department Based Teams (DBTs) throughout BPMC, building on the experience with a number of such teams formed to do joint work on department issues. An example of these earlier efforts was a joint team that came up with cost savings in 2001 to address a serious budget problem in the Department of Food and Nutrition Services.

In late 2002, the Steering Committee decided to expand DBTs throughout the Medical Center. Medical Group Administrator Rick Rosoff explained that “*We wanted to touch as many people as possible rather than have Partnership at the 40,000 foot centralized level, and focus on specific projects at a more decentralized level. To improve the overall scores at BPMC we had to have all parts involved.*” He points to this approach, with departmental goals and accountability, as distinctive: “*What’s different here is that in most other areas the labor management partnership is rolled out at the service area level. We felt it is impossible to do this. It’s better for a facility like Baldwin Park to have local accountability.*”

The Steering Committee sent a memo to each Department Manager asking the department to establish a DBT by the end of the 1Q03:

*“The Baldwin Park Steering Committee, after providing Labor/Management Training to over 50% of the partner union staff during 2001, is now looking to weave the partnership into our strategic and operational processes. We want to utilize the partnership to improve performance by integrating the partnership into the actual running of our business, and the day-to-day activities of our employees, managers and physicians. In addition, we want staff to understand that the business goals and the Labor-Management goals are the same.*

*We believe that it is now time to build on, and complete the training begun in 2001, and establish a common forum in each department for the Labor/Management Partnership work to be accomplished. We call these forums Department Based Teams.”*

A manager describes the DBTs that are now operating as the “*strength of the partnership today.*” This is echoed by UNAC/UHCP Labor Liaison Jacqueline Asfall, who points to establishing DBTs, some of which have “*captured the vision of the Partnership and taken ownership,*” as a key Partnership achievement.

The Steering Committee's guide to establishing and operating DBTs was posted on the Southern California LMP website as a "best practice" resource for others. This guide directs teams to carry out specific medical center-wide initiatives (for example, in 2003 the Steering Committee asked each DBT to focus on improving the patient care experience). In addition, the DBTs are encouraged to identify their own projects to work on. According to one Steering Committee member, enabling the teams to be pro-active in choosing what they want to work on "*motivates them.*" Both rank and file union members and frontline managers can go beyond the priorities set by higher levels to work on matters that affect their working environment and department effectiveness.

By 2004, there were approximately 38 Department Based Teams (some involving more than one department). At least on paper, only two departments with partner union staff had not formed a DBT. In terms of sheer scale, this represents a substantial investment by BPMC in Partnership: each team is scheduled to meet at least monthly, with meetings ranging from one hour to close to a full day. DBT membership ranges from 3 to over 20, with approximately 350 BPMC managers and employees involved overall. The Steering Committee acknowledged that DBTs would require a significant investment of resources, stating in its memo asking each department to form a team:

*"We believe that the best way to achieve these improvements [in Patient Care] is through the labor/management, interest based, and problem solving process...We understand that having a Department Based Team requires time, resources and support. However, we believe that this is an investment worth making..."*

Not all of the DBTs in fact met regularly in 2004, and at least five were described as "struggling." The 2004 performance scorecards for some BPMC Departments include a stated "LMP goal" to plan or maintain the Department Based Team. One Department Administrator who is the sole manager in her small department explained her support for the Partnership team model: "*Because of lean management [in this unit] it would behoove anyone with intelligence to get buy-in to make things work.*"

### *Sponsorship and Accountability*

The DBTs are "sponsored" by Steering Committee members, and expected to report on a quarterly basis to the Steering Committee. Each team is assigned one or two Steering Committee member sponsors, who serve as a resource to coach and facilitate, and as a communication link with the Steering Committee.

The stated aim is for the DBTs to become self-directed, with a gradually reducing role for the Steering Committee member sponsors. In mid-2004, the Steering Committee members were tasked with completing a "Self-Directed Check-off List" for each of the DBTs they sponsored, in order to determine

whether or not the DBT could be designated as self-directed, after which the Steering Committee sponsor would not be expected to attend each meeting. The checklist designed by the Steering Committee for this assessment states seven measures for assessing when the DBT can be designated as “self directed.” Sponsors and DBT co-chairs were both asked to respond whether:

1. *all DBT members have completed required LMP training (LMPO, IBPS/CDM, MAPPS, UPR);*
2. *the team meets at least once a month;*
3. *A “preference, not a “requirement” that DBT Chairs have attended or will be attending facilitation skills training;*
4. *DBT can demonstrate that they have designed and implemented (or are in the process of implementing) a department project or initiative;*
5. *DBT is functioning well with sponsor attending meetings on an ad-hoc basis;*
6. *DBT has an effective communication process within the department to distribute and receive information;*
7. *The team submits DBT Report Forms to the Steering Committee on a quarterly basis.*

Some of these measures are objective; others require judgments. Once the checklist is completed, it is returned to the Steering Committee for final review and, where determined appropriate, approval for the team to become self-directed.

This project to assess the DBTs bogged down, and only a quarter of the forms were completed by the end of 2004. Follow-through appears to have been suspended as the Steering Committee’s focus was diverted to problems meeting performance sharing program goals on attendance, customer service and workplace safety. One manager commented that *“getting stuff back is not always easy because of staffing issues, time and it requires thought.”*

#### *DBT Charter/Purpose*

The Steering Committee developed a model charter as a guide for the DBTs. This guide states five long-term goals for the teams:

1. *Achieve superior business results by taking a partnership approach to managing the department.*
2. *Build a department in which partnership efforts are woven into strategic and operational processes.*
3. *Create an environment of shared responsibility, accountability and decision making.*
4. *Carry out agreements worked out through the national and local bargaining process.*
5. *Implement the partnership goals and objectives as set forth by the region, service area or local medical center.*

In addition, the Steering Committee described the “purpose” of the DBTs as providing “oversight to advancing the Labor Management Partnership and enhancing the patient care experience within the department.” The ten points that elaborate on this purpose address (a) KP organizational success (“improve quality of health care for KP members,” assist KP in “achieving and maintaining market leading competitive performance,” “expand KP’s membership”); (b) the KP workplace (make KP “a better place to work,” “provide KP employees with maximum possible employment and income security,” “involve employees and their unions in decisions,” support “cultural change initiatives”); (c) identify and sponsor Medical Center and Department initiatives; and (d) implement the Partnership (report to and work with the Steering Committee, model LMP behaviors.)

A review of charters adopted by a sample of DBTs indicates that some track the Steering Committee’s guide charter more closely than others, and none simply adopt it in its entirety. Teams invested time and attention to shaping their charters. In mid 2004, one team was reviewing and wordsmithing its’ charter as an “old business” agenda item close to two years after the team was first formed. Another DBT decided to review its Charter Vision Statement at the beginning of each meeting.

The charters adopted typically highlight improving both the workplace environment and service. Most include language concerning the Partnership – “implementing partnership goals,” “collaboratively advance Labor Management Partnership.” Half of the ones reviewed talk about taking a team approach, involving employees in decision making. Provisions that were not found in the Steering Committee’s model include, for example, developing a “sense of business ownership in the staff.” The Call Center’s charter is a succinct example:

*“To create a TEAM environment of SHARED responsibilities and accountability and decision making in which we provide superior services to our customers both Internal and External. Building a department in which partnership efforts are woven into strategic and operational processes. Thus making our department a better place to work.”*

### *DBT Norms and Boundaries*

The Steering Committee’s model “norms and boundaries” highlights using consensus decision making, tracking activities, holding regular meetings (at least monthly), paying members for attending official team meetings, and recognizing the boundary that Union and KP leadership must approve any “redesign [of] jobs or work content.”

As with their charters, individual teams have shaped their own norms and boundaries. A sample of team charters reviewed address both individual member

behavior and how meetings are run. Examples concerning individual behaviors include: turning off cell phones, one person speaks at a time, valuing differences, not dominating discussion, confining discussion to topic at hand, don't interrupt, confidentiality, commitment to attend. Examples of norms on how meetings will be run include: consensus decisions, start and end on time, defining a quorum (including differentiating a quorum based on issues – e.g., with a doctor related issue, a doctor member is part of the quorum), preliminary agendas to be discussed at the close of the prior meeting. With respect to team decision-making, most teams have adopted an express commitment to make decisions by consensus.

On boundaries, some teams have adopted the Steering Committee's language specifying that certain issues – concerning redesign of jobs or work content -- require prior approval from the union or management. One team circumscribes the scope of its work as “*departmental and interdepartmental issues which they have an influence over;*” and expressly excludes “*contractual or administrative issues they have no control over.*” Another team has limited its authority by providing that improvements it suggests “*will be presented in the form of recommendations to the department members.*”

Meetings observed and minutes reviewed suggest that much of the work of the DBTs is in the nature of deciding what to recommend to others. One Department Administrator, commenting on the limits in her DBT's ability to make decisions directly, offered her view that “*as the [Medical] Chief becomes more confident in the DBT's recommendations, they will be accepted more readily and the line between recommending and deciding will be largely about process.*”

### *Team Membership*

All teams include union and management representation, and some also include physicians. A manager and union member typically serve as co-chairs. Some teams have tri-chairs (two union members from different unions), paralleling the Steering Committee's structure.

In most DBTs, labor members are elected by the union members they represent. For example, at the West Covina Family Clinic DBT, UNAC/UHCP members elected an RNP (who became the team's co-chair) and an RN; Local 399 elected a Licensed Vocational Nurse and Medical Assistant. In another DBT, members are solicited as volunteers, with an election held only if the number of volunteers exceeds the number of members needed. In another, all union members are described as volunteers.

Physicians participate as members in some DBTs (10 out of 38 have MD members). Two of eight members of the West Covina Family Practice DBT are doctors, who are expected to regularly report to their colleagues about DBT activities. Commenting on the participation by doctors in the Partnership, one

manager acknowledged “*This is the one area in Baldwin Park we need to work on. But we always have to weigh access issues – taking them out of their offices for this.*”

In some teams, the manager co-chair is the sole management member. In some cases this reflects the reality of a small department that has only one manager. But this is not only the case in small departments. For example, all ten members of the Perinatal DBT (in addition to the co-chairs) are equally divided between UNAC/UHCP and Local 399. Management participates in larger numbers in other teams. For example, the Dietary Services DBT has, in addition to its co-chairs, seven members: four are managers, three are from Local 399.

In some DBTs, the Department Administrator serves as the management co-chair; in others, he or she is a designated member of the DBT; and in still others the DA is not even a member of the DBT. Regardless of the number of managers in the room, they typically dominated the discussion in all DBT meetings observed in this research (in contrast to the Steering Committee meeting observed, where leadership and participation was far more fully shared between labor and management). In one DBT meeting, the strongest leadership role – presenting information and effectively leading brainstorming -- was played by a Clinical Director who was not a co-chair or DBT member. One management Steering Committee member sees the success of the DBTs as depending upon whether individual managers are “*willing to let go.*” Another variable is the extent to which rank and file workers develop the confidence and skills to move into leadership roles.

Some concerns were expressed about the process for selecting members of the DBTs (and other Partnership workgroups as well). A Hospital Executive described as a key challenge for the Partnership “*choosing people for DBTs or projects, since labor still chooses labor members and managers choose management members.*” A department manager also pointed to this as a challenge: “*Who names staff to LMP committees? Union politics leads to picking people who are not necessarily interested...I'd like to choose members by asking for a vote, screening and selecting. Get people who want to participate.*”

### *DBT Member Training*

The Steering Committee’s guide identifies five different trainings that all DBT members need to receive (LMP Orientation, Root Learning Maps, IBPS/CDM, IR/CA and UPR). DBTs report to the Steering Committee on the number of members trained on these, as well as MPE training (which was initiated in 2004) and customer service training. The Steering Committee’s check-list assessment for determining whether teams could become “self-directed” provides that facilitation skills training for DBT chairs is a “preference; not a requirement.” In addition, some unions set requirements or

recommendations for union training. UNAC recommends members serving on DBTs to take basic and advanced rep training. In mid 2004, Local 399 met with some resistance when it established this as a requirement.

*DBT Portfolios: Alignment with BPMC Priorities and Opportunities for Departmental Issues*

- *Patient Care*

The Steering Committee's memo asking all departments to establish a department based team emphasized the goal of improving patient care as both a reason for forming teams, and a priority for their attention:

*One of the Medical Center's (and therefore Steering Committee's) 2002 Strategic Goals is to improve on the "Patient Care Experience." Each department has also chosen improving the Patient Care Experience as one of their goals. We believe that the best way to achieve these improvements is through the labor/management, interest based, and problem solving process. To that end, we are requesting that each department establish a Department Based Team by the end of the first quarter, and utilize these groups to improve the Patient Care Experience.*

In 2004, customer service -- for patients or internal KP customers -- continued to be a common DBT agenda item and project focus. This comports with the 2004 BPMC Performance Targets Scorecard, which identifies service -- "Caring with a Personal Touch" -- as a major performance measure category. Outpatient departments are engaged in the Building on Excellence initiative, described below. An example of an inpatient department's DBT focus on service is the Perinatal DBT. This team used the IDEO program to develop more customer friendly practices for patients. Outcomes included implementing Spanish birth tours and "My Journey" (which takes a patient throughout the steps from delivery to discharge). UNAC/UHCP Labor Liaison Jacqueline Asfall describes the joint work on this program as "*increasing understanding and ownership of the organization which includes the Partnership, empowering employees with decision making tasks contributes to the strength of the Perinatal DBT -- it's going strong with high participation.*"

At its June 2004 meeting, the Perinatal DBT heard a detailed report on the most recent service scores (the KP "Picker" survey scores), which showed "highest ever" improvement for BPMC in the fourth quarter of 2003, and then a steep decline in scores in the first quarter of 2004. DBT members discussed the data, attempting to understand the decline, particularly on the "emotional support" dimension, which is one of two inpatient care measures affecting performance pay. The team spent time brainstorming actions to improve areas where responses showed the most significant negative variance from the regional scores and large declines from the prior quarter. For example, drilling down in this emotional support dimension led to brainstorming on how nurses could do

more to discuss with a patient her anxieties and fears. Three members agreed to work on this as an ad hoc team and bring a list of ideas to the next meeting. In addition, the DBT discussed how to get more immediate information than available through the quarterly Picker score reports, through increasing the collection of Patient Satisfaction Questionnaires before a patient is discharged.

- *Workplace Safety*

In mid 2004, all DBT meetings observed devoted time to workplace safety. Nine BPMC departments with double digit injuries per month were initially identified to receive “Systems of Safety” (SOS) training on how to analyze injury data, and develop solutions. Once systems have been diagnosed, departments could request money from a tri-central committee to implement changes. DBT meetings discussed the SOS safety plans and funding requests. The plans outline short term and long term changes to reduce injuries. The Perinatal DBT, for example, identified short term changes ranging from ordering Hovermatts (cost: \$6,800), to installing temporary signage on swinging doors (cost: \$50). In this and another DBT meeting, management took the lead – reporting on difficulties in getting funds to make the changes designed, and data on the continuing problems with injuries. In one DBT meeting, discussion about workplace safety was led by a Steering Committee union member. In general, workplace safety discussions conveyed that there is a sense joint responsibility for this area, as illustrated by one union member talking about meeting workplace safety goals who asked “*what will we do*” to meet the safety goals.

- *Attendance*

An example of DBT activities to improve attendance is the incentive awards created by one team for staff who achieve “perfect attendance.” Concerned that no one had yet qualified for the award, a management member asked whether the standard for the award -- no call-outs, no lates, and no missed dates -- should be lowered. Two union members were quick to insist that the high standards be retained. Another example is the West Covina satellite medical office’s Family Practice DBT, which began working on the problem of sick leave after the clinic (with its staff of 100) was identified as a “top user of sick time”. Department Administrator Brenda Mikhail, the DBT co-chair (and only management member) describes how a DBT subcommittee working on this problem “*discovered that we needed to clean up how leave was coded, and this made a small difference. But what really worked was the idea that came up in brainstorming to meet with every staff member, not just ones who were taking a lot of sick leave, and show each person written information about how much sick time, vacation time, they were using.*”

In addition to these DBT activities, a joint team created an Attendance Toolkit. The language was run by each of the unions and management. Once it was approved, it was introduced initially in departments with high absenteeism, and then extended to others.

- *Cost-Saving Initiatives*

DBTs also spend meeting time on understanding budget issues and achieving cost savings. The Perinatal DBT has worked on generating savings by reducing linen costs. At a mid-2004 meeting, after a management participant reviewed the department's financials and the shortfall caused by payroll expenses against a low patient census, a union member suggested another way to find additional savings on linen costs. The relatively minor impact of linen costs on the budget shortfall, and the importance of reducing overtime costs by trying to fill needs on straight time, was discussed. Another example of a DBT working to find cost savings is one where, through brainstorming, a new way to locate the light attached to the pap smear speculum was designed: instead of keeping it in a draw (which causes damage to the cord), putting it on a hook to be handy would avoid the dangers and replacement expense of a frayed cord.

Although not a "department team", the joint work by a Food and Nutrition Project team in 2001 produced recommendations that overcame the Department's budget shortfall. In the first six months of the year, despite cost cutting steps that had been implemented, the Department was under budget at the rate of \$30k per month. Prices were raised 10%. Eliminating the sandwich making and salad bar was rejected as outsourcing. Costs continued to rise. An "off line" LMP team (not department-based) was created, "*to utilize the Interest-Based Problem Solving process to develop solutions, final recommendations*" with the criteria that the solutions be "*within guidelines of the National Partnership Security Agreement ... viable ... maintain quality and service standards.*" "Sponsors" included two leaders from the Tri-Central Area (Greg Adams, then Tricentral Service Area Manager and Greg Christian, Service Area Support Leader), institutional union leadership (Dave Bullock, then Local 399 Executive Director), and top BPMC management (BPMC Medical Group Administrator Rick Rosoff and BPMC Director of Hospital Operations.)

Six members of the team were from labor, and three from management. Of the six labor members, half were rank and file who worked in the Department. All three managers were from the Department (Department Administrator, Asst Dir for Public Services and Asst Dir for Patient Services). The team's mandate was to use IBPS to develop solutions and make recommendations that are "viable and solve the problem, while maintaining quality and service standards." The time schedule was tight: one week to prepare, one week to produce.

Just-in-time training was given team members on finances (root learning map and financial & data analysis overview), partnership (overview), the Optical Lab case and skills training (IBPS and consensus decision making). In three days of facilitated work, the team generated three dozen or so ideas in five areas: improve staffing/scheduling and overtime; improve services and products; expand catering; improve utilization; strengthen the partnership. These were

presented to the Steering Committee, and then to management. Roughly five of the changes were implemented.

According to Labor Liaison Shirlee Shirley, changes were made in staff work assignments and work hours to share the work “more equally.” The written report shows that 3 FTE’s and overtime were reduced. Shirley described that workers accepted the changes in their job responsibilities “*because we showed how if you do this we’d take this [other responsibility] away and give it to another person*” and because they “*could trust*” the union participants. Also, there were changes in food service – reducing the different types of orange juice from eight to two. Within six months the budget overage was recouped. In the same six month period the following year, the department was running \$20k better than budget (compared to \$177,000 in the red). Most of the difference was in payroll costs.

- *Department Projects*

Teams also work on projects specific to their Department. This presents an opportunity for the DBT to set its own agenda and not be totally driven by the Steering Committee and/or management. Examples of activities undertaken by individual DBTs include: bringing an ATM machine to a clinic, designing a 4/10 work schedule, getting “night and day shift staff to work as a team,” handling duties when a staff person goes on vacation. One Steering Committee sponsor described work by a DBT she sponsors on a problem with the referral and triaging of calls. Through an interest-based problem solving approach, the DBT established a new process for message referrals and flagging priority calls. This type of problem, which was initially raised by one staff person, could have been sent to “issue resolution.” The sponsor sees the DBT’s involvement as creating a much different and more constructive staff dynamic. In effect this is an example of substituting group problem solving for issue resolution.

### *Engagement and Capacity: Strengths and Challenges*

- *Communication*

Communication with department members who are not on the DBT is a challenge: e-mail capacity isn’t universal, an accessible paper trail is difficult to maintain, and it is difficult to create additional meeting time for an overstretched staff. Communication difficulties are not limited to staff -- one DBT identified communication difficulties, especially with MDs, as a barrier to the success of the team. DBTs maintain minute binders in places intended to be easily accessible, but the information isn’t easily kept up to date, and a shared resource isn’t always examined. Few DBTs have assistants to record minutes. Handwritten minutes as the official record can be difficult to understand. A labor member on the Steering Committee describes the biggest challenge as getting people to make the connection between changes at BPMC and the Partnership.

- *Unions' Representational Role*

Even though union members on the team typically are elected, the union members they represent do not necessarily view them as having authority. One DBT identified as a barrier that “*Department staff is not readily accepting the committee's decisions.*” This was echoed by a manager who described as the “biggest challenge” to her DBT that “*when the group in the room agrees, how assure it's what the unit wants?*”

The election of team members by bargaining unit colleagues also does not necessarily lead to their identifying themselves as union representatives or responsible to the union. In several DBT meetings observed, members rarely mentioned their union affiliation as they introduced themselves. The same manager quoted above commented that “*DBT members see themselves as there for the staff/unit, more than for the union.*”

Both UNAC and Local 399 offer union training to DBT members. With UNAC, this training is “recommended,” and the shift structure nurses work makes it possible to attend the training without losing a day's pay; in addition the training entitles UNAC members to continuing education credit, which they need to accumulate. Local 399's members, in contrast, generally need to miss work (and pay) to attend the training. As a result, Local 399's decision, in 2004 to require that DBT members attend steward training, met with some resistance. As one team member commented: “*We're not getting paid. I don't want to loose 12 hours to do this.*” There was a heated discussion about this resistance in a Steering Committee meeting, which escalated after a manager asked the union to reevaluate the requirement which “*serves no purpose.*” After 399's business agent responded to this forcefully, another manager said “*we're not objecting.*” It became clear that management was not the best messenger to tell the union members to go to the steward training, especially when management did not understand why this was being required. After the business agent explained 399's reasoning, and that she's been able to persuade members of the value, it was suggested that all objecting staff be referred to her. One manager, however, said that if she had an information sheet from 399 she would be able to hand it out, and also explain the reason for the training – becoming a far more effective messenger about the requirement.

- *Relationship between DBT actions and Contract*

Training, including the required LMP UPR training, does not assure DBT members will identify contractual boundaries to team action. The value of effective coaches (a Steering Committee sponsor role) was illustrated in one meeting observed when an idea that potentially affected contract provisions was proposed. After no DBT member raised concerns, the sponsor quietly coached the management chair that the change being suggested (which would effectively redefine shifts) could not be done without involving the union because of contract

implications. A similar idea surfaced in another DBT meeting was not flagged by anyone present.

- *Transition in membership*

In general, DBT membership turnover poses difficulties, as happens with any group that has learned how to work together -- one DBT pointed to frequent changes in membership as a barrier. In another department, staff challenged who was serving on the DBT, and asked for new elections (the DBT had extended the term of its members from one to two years, in order to reduce turnover disruptions.)

- *Backfill Challenges*

When union members participate in DBT meetings, covering their other responsibilities puts pressure on other staff and can breed resentment. As one DBT reported “*employees are overwhelmed with work,*” and identifies as barriers “*staffing coverage*” and “*additional duties not agreeable.*” A labor member on the Steering Committee identifies this, and the time to participate, as a “*huge challenge*” for the DBTs.

- *Finding time to invest in Partnership responsibilities*

With the exception of the full-time Labor Liaisons, everyone at BPMC participating in DBTs, the Steering Committee, and other Partnership activities, has this added to the other responsibilities of their jobs. Some managers see this as how they can best manage their departments. But for others, carving out time for meetings is more difficult. One of the byproducts becomes problems with follow-through. For example, the Steering Committee back-burnered the DBT assessment process it had invested time to initiate, when it realized BPMC was behind on targets on attendance, customer service and workplace safety in fall 2004.

- *Manager Commitment*

The Departments having difficulty moving forward with effective DBTs were typically described as ones where the Department manager was resistant to the idea. One union Steering Committee member described progress on this front: “*I’ve seen the department based teams turn around managers...We were talking today about a manager who was adversarial. It was her way or no way...I’m now hearing wonderful things about this manager...The Partnership through working with her and being ever so patient but firm have turned her around. And that is awesome.*”

- *One Physician's Participation*

As indicated earlier, there is physician participation in just over 1/4 of the DBTs. In a meeting of one DBT with a physician member, observed in mid-2004, the team gingerly discussed problems caused by physicians running late on appointments –adversely affecting patient satisfaction and increasing the department's payroll costs by causing incidental overtime for medical assistants. As these problems were explained, the physician member listened and asked questions to understand the ramifications, but expressed the importance of deferring to individual doctor's judgments about their schedules. On another topic, the anticipated reassignment of duties when the department's sole RN was on vacation led to a fairly frank discussion about how the doctors' actions were increasing the volume of calls for the sole RN to handle. The physician member agreed to talk with his colleagues with specifics on the problem, and present a plan if the team developed one to test. The manager co-chair explained that any change in how the messages were handled would need to go to the Medical Chief for approval.

- *Meeting Management and Use of LMP "tools" -- Interest-based problem solving, brainstorming, facilitation, and consensus decisions.*

The fact that team members are trained in interest-based problem solving and partnership does not assure that they are able to work together effectively. One DBT identified as a "barrier" the "*difficulty with having employees work as a team to accomplish common goals,*" and "*sense of inability to effect change.*"

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

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

At one DBT meeting, consternation about a supervisor rotation plan revealed that the manager, who was preparing to implement this plan,

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

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

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

While these are just two examples taken from the meetings observed, they illustrate the critical importance of effective leadership and meeting management skills.

### **C. Aligning Partnership Work with BPMC Priorities: The Building on Excellence Initiative**

In April 2002, the BPMC Partnership Steering Committee adopted a department-based customer service initiative it calls “Building on Excellence” (BOE), in order to improve the patient care experience in outpatient units. At the time, data showed that BPMC was one of the lowest scoring medical centers in the region. In 2002, “ASQ” survey scores, one of two instruments used for measuring patient satisfaction in outpatient departments, revealed several problem areas. After learning about an initiative developed by Bobby Duncan, Tri-Central Service Area Consultant, and piloted at Long Beach Medical Center, the Steering Committee decided in April 2002 to go forward with an initiative

modeled on the Long Beach pilot. The following year, the Steering Committee designated “improving the patient care experience” as a priority for all Department Based Teams.

BOE was initially implemented in 12 outpatient departments identified as having a significant need for improvement in their service scores, and another 10 departments that volunteered. An “LMP Customer Service Charter Team” was created to oversee the BOE initiative, with management and labor co-chairs. This team meets monthly to review service scores, discuss progress and plans for improvement. In addition, “customer service advocates and coaches” are chosen from each participating department. By mid 2004, over 100 service advocates and coaches had been trained – 75 of these were chosen by labor to be service advocates to mentor their peers. A small number of physicians are also service advocates. Managers are coaches. An effort was underway in mid 2004 to designate at least one advocate on every DBT.

The service advocates and coaches meet monthly to share new ideas about improving service from their departments, and are trained to lead a monthly session – a 20 minute “mini-module” – to keep the focus on service. In June 2004, for example, the mini-module was about how to end interactions with KP members in a positive way. Additional components of the BOE initiative include member surveys, employee opinion surveys, and periodic telephone mystery shopping.

The program design materials explicitly address the role of the “Union Rep,” noting that there will be times when advocates are mentoring and coaching their peers. The roles statement explains that *“because this isn’t a disciplinary program there shouldn’t be a need for Labor to have a Union Rep. available when being coached or mentored.”*

Metrics to measure results are part of the design of this initiative, utilizing KP ASQ and METEOR service measures, and On-the-Spot awards in each department. The ASQ survey is administered to Kaiser Members by mail a week after they visit the Medical Center for service, so a particular experience is fresh in the respondent’s mind. Data from these surveys are generated for individual departments, and therefore this is a particularly useful tool within the Medical Center. The METEOR survey instrument is sent to Kaiser Members every 12 months, and asks about the member’s experience over the past year. This data is reported only for the Medical Center as a whole. While it is therefore less useful to the Medical Center as a tool, it is the data relied on in regional and national review. In addition, the METEOR measure concerning “helpful and courteous staff” is a component for determining variable performance pay, and therefore is a particular concern. This measure asks Respondents about service received in the last 12 months, for example: how often did office staff at a doctor’s office or clinic treat you with courtesy and respect; and how often were office staff at a doctor’s office or clinic as helpful as you thought they should be?

ASQ survey targets were established for BPMC departments, with a goal set based on current survey results (along with a stretch target). The key ASQ areas being tracked in the BOE initiative are:

- Overall Satisfaction
- RN Interest and Attention
- Ancillary (non-MD) Courtesy

Reports on the progress of departments participating in BOE are regularly presented to the Steering Committee, Department Administrator meetings, and department meetings, and at meetings of the BOE charter team and customer service advocates/coaches. In June 2004, the Steering Committee and customer service advocates grappled with contradictory results from the ASQ and METEOR surveys. The ASQ results were showing steady improvement, and departments consistently exceeding targets that had been set. The 1Q04 METEOR score for whether staff was “helpful and courteous,” however, was 3% below the BPMC goal (of 90%) on this composite measure (the regional goal is 92.5% by 2007), and the lowest compared to other medical centers in the service area. Looking at the questions within the composite, BPMC scored better on the “courteous” part of the composite -- whether the “office staff treats you with courtesy and respect” – than it did on the helpful part -- whether staff is “as helpful as you thought they should be.”

Participants in Steering Committee and customer advocate meetings observed struggled to understand the distinction between the results on the two surveys, the difference between “helpful” and “courteous,” and why BPMC was scoring better on the ASQ survey than on METEOR. At the Steering Committee meeting, participants moved from this discussion into brainstorming about how to improve on the METEOR measures, and subsequently training to improve staff “helpfulness” was instituted as part of the BOE initiative.

With respect to the role of the Partnership in enabling an effective focus on service, one manager commented that before “*it was generally only leadership or management running everything. This empowers staff.*”

#### IV. Outcomes: Relationship and Substantive

##### A. Indirect Results: Changes in Partnership Readiness, Capacity and Engagement

- **People Pulse Survey**

People Pulse data (November 2003<sup>4</sup>), indicates a high level of knowledge and involvement in the Partnership at BPMC. The responses on this question indicate greater engagement at BPMC than in the Southern California region and the KP norm. This comparison suggests that BPMC's investment in training and department based teams has made a difference.

On the question “*How much I know about LMP,*” BPMC scores 9% higher than the Southern California region, and 21% higher than the KP norm. *See Figure 1.* This pattern is similar for the question about “*personal involvement in LMP activities,*” although the gap is smaller. BPMC Respondents report LMP involvement to a greater extent than respondents in Southern California (+5%) and the KP norm (+15%).

*Figure 1*

<b>Measure (November 2003)</b>	<b>BPMC</b>	<b>SCal Region</b>	<b>KP Norm</b>
How much I know about LMP	58%	49%	37%
Personally involved in LMP	47%	42%	32%

The response within BPMC on these two questions reveals a significant increase in LMP engagement since 2001 in both the Medical Group and the Hospital components. *See Figure 2.* However, it also reveals greater engagement in the Medical Group than in the Hospital. On the question “*How much I know about LMP,*” the Medical Group responses are 10% higher than the Hospital. This gap has been created since 2001, when the responses in both components were similar. For the Medical Group, reported knowledge about LMP has increased 30% since 2001; for the Hospital, the increase of 18% was also substantial, through smaller.

A similar pattern of difference between the Medical Group and Hospital is seen in responses to the question about *personal involvement* in LMP: 11% more BPMC Medical Group respondents report involvement in LMP than is reported by BP Hospital respondents. *See Figure 2.* Here again, the gap has been created since 2001, when the scores for both parts of BPMC were identical. In both components, there has been an increase since 2001 in respondents

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<sup>4</sup> The 2004 People Pulse data was not available prior to completion of this report.

reporting personal involvement. But the increase is twice as large in the Medical Group as in the Hospital.

Given the Partnership's emphasis since 2001 on training and establishing department based teams, it is not surprising to see a significant increase on these LMP knowledge and involvement measures. The distinctions between the Medical Group and Hospital components are more difficult to explain. As *Figure 2* indicates, there are a number of significant increases since 2001, and differences between these two components.

*Figure 2*

<b>Measure (November 2003)</b>	<b>Med Group (% &gt;2001)</b>	<b>Hospital (% &gt; 2001)</b>	<b>Diff between MG &amp; Hosp</b>
KP is a good place to work	88% (+18%)	82% (+18%)	MG + 6%
Ideas about improving care used	48% (+10%)	43% (+11%)	MG +5%
Mgt uses employees ideas	47% (NA)	41% (NA)	MG +6%
Influence over decisions	38% (+9%)	36% (+8%)	--
Regular team meetings	72% (NA)	67% (NA)	MG +5%
Good place for healthcare	85% (+11%)	80% (+20%)	MG+5%
Supported to satisfy customers	63% (-2%)	77% (+21%)	Hosp + 14%
Trust information	61% (+6%)	69% (+24%)	Hosp + 8%
Training for service	72% (+12%)	78% (+22%)	Hosp + 6%
How much I know about LMP	63% (+30%)	53% (+18%)	MG +10%
Personally involved in LMP activities	53% (+21%)	42% (+10%)	MG +11%

Different explanations were offered for the lower levels of LMP awareness and participation in the Hospital. One labor leader and manager each suggested that the differential reflects leadership's commitment to Partnership, and that senior leadership in the Medical Group is more committed than in the Hospital. Others suggested that any differences between the two components are due to structural, rather than leadership, reasons: the 24-hour hospital operation means a large number of night shift employees, who typically are less involved in Partnership activities, and also have high turnover. However, since the Medical Center operates with an integrated management structure – with outpatient and inpatient departments sometimes reporting to the same senior managers, this generalized link to either leadership attitudes or structure seems unlikely. Given the richness of this internal data, and BPMCs efforts at the department level, it would be useful to more thoroughly cross analyze department results. This was not possible with the 2003 survey data.

- **Changes in Capacity (Training)**

As described above, BPMC is pursuing the goal of training everyone who works at the Medical Center in partnership tools (IBPS/CDM/IR), LMP orientation. As of February 2005, 67% of union and management employees had attended LMP Orientation. A smaller number, approximately 20% of union and management employees, had attended IBPS training.

In addition, as of February 2005, 10% of union employees had attended UPR training and 50% of management employees had attended MPE (Managing in a Partnership Environment) training.

## **B. Direct Results**

- **Patient Service**

The Partnership is regularly tracking results on patient service measures, using a number of different KP survey reports. Outpatient department service is evaluated using both the METEOR Survey, which is administered to patients on an annual basis, and the ASQ survey, which is sent to patients a week after they've received service. Inpatient departments are evaluated through the Picker survey.

There are several indicators of improved outpatient services. The ASQ scores for all BPMC outpatient departments through the third quarter 2004 exceeded the "stretch" goals on each measure. In contrast, in 2003 BPMC was "above goal" on only one measure. The steady nature of the improvement in outpatient ASQ service scores is seen by comparing 2004 with 2002 – with increases ranging between 2.9% and 8.7% (the key measures BPMC is tracking are highlighted).

<b>ASQ Measure (key targets being tracked are shaded)</b>	<b>2004YTD (to 3Q)</b>	<b>2004 Stretch Goal</b>	<b>2002</b>
Overall Visit	88.1%	87.6%	85.2%
Phone Access – Primary Care	72.6	71.1	63.9%
Phone Access-Specialty	74.8	74.3	68.0%
Appt Access – Primary	69.8	66.8	63.7%
Appt Access - Specialty	71.9%	69.5%	66.7%
Non-MD Courtesy	83.3%	81.9%	79.2%
RN Interest/Attention	86.5%	86.1%	83.1%
Help/Advice	71.5%	70.1%	67.1%
Wait > 15 minutes	71.5%	70.1%	66.2%

Looking at the departments participating in the Building on Excellence initiative, Bobby Duncan reports that on pretty much every question, ASQ scores had increased nine quarters in a row. In addition, he reported in mid 2004 that the BPMC ASQ scores showed the most improvement when compared to other Medical Centers in Southern California

Improvement is also seen in another measure utilized in the BOE initiative: the reward/recognition program. The goal was set to increase the number of on-the-spot awards given each year in a department. Since over 95% of these awards come from Kaiser Members, it is considered a valid measure of service. The number of on-the-spot awards in 2004 is double the prior year, which in turn had doubled the number from 2002.

The METEOR survey results in 1Q2004 reveal a less successful picture, though this may reflect a typical lag due to the timing of this survey. BPMC was above the regional average on 3 of 4 "overall ratings:" overall rating of MD/Nurse (where it ranked third out of 12 regional medical centers), overall rating of health care (ranked fourth), and overall rating of specialist (ranked first). BPMC was below average on the overall rating of the health plan (seventh), but this does not as easily correlate with employee service. On the composite measures reported in the METEOR survey, however, BPMC scored below average on 4 of 5 staff-related composites. For one of these, BPMC's score was the lowest of all medical centers in the region: helpful and courteous staff scored 88.2%, compared to the regional average of 91.5%. By 3Q 2004, the BPMC score on this composite had increased to 90.7% (and BPMC had improved its ranking to seventh among the medical centers). With this improvement, BPMC's 2004 average was increased to 89.5%, just shy of the regional 90% goal for the year.

- **Attendance**

As noted earlier, the West Covina satellite medical office's Family Practice DBT began working on the problem of sick leave after the clinic (with its staff of 100) was identified as a "top user of sick time". In the first eight months of 2003, the reduction was from 27.61 to 8.01 (an undesignated portion of this was due to coding corrections). While 2004 data indicate that the number hasn't stayed this low, neither has it returned to the previous high: for 2004, the average sick leave per FTE was 11.95.

With respect to BPMC overall, however, there has been a backsliding on attendance. In early 2004 progress was reversed, and the Partnership focused renewed attention to this, including developing the Attendance Toolkit described above. By the end of 2004, the attendance numbers were reportedly improving. But there was concern about the erratic nature of attendance results, and one labor leader expressed determination to bring the numbers down and *maintain* the improvement. One recurring problem continues to be in coding absences correctly.

- **Workplace Safety**

Using the Systems of Safety approach, the BPMC Chart Room employees and management identified the need to break down the files staff moved around when a file needed to be pulled or returned -- each one weighing between 4-5 pounds. With an additional \$24,000 granted by the service area SOS committee for overtime and equipment, in two months, staff completed 300,000 files. The number of injuries reported decreased -- the department reports that it had only one injury from November 2003 to June 2004 (compared to at one time 42 injuries per year). But as new charts get added at the rate of 100 per day, the committee went back to request additional funds for deactivating files. At the June DBT meeting members learned that it was unlikely they would get the full additional \$34,000 the department had requested to this preventive work.

By mid 2004 BPMC was below the regional target for workplace safety improvements, but by the end of end of the year both actual injuries that result in compensation claims and supervisor reports of injures, were reportedly cut in half.

### **C. Indirect Results: Diffusion**

The BPMC Partnership has made a concerted effort to proceed systematically, and enable replication of its initiatives. This is illustrated by the guidance developed for the DBTs, the attendance toolkit, and the Building on Excellence initiative. The DBT guidance is posted on the Southern California LMP website, as is the Attendance Toolkit.

## V. Concluding Thoughts

The BPMC experience illustrates the extent to which Partnership is a continuous “work-in-progress” – a journey and not a destination -- and the reality that the road traveled is not always straight. Confidence in the strategy of partnership is an important element in sustaining it when difficulties arise, and the initial achievement of opening the Baldwin Park Hospital with labor management collaboration created deep internal support for this strategy at BPMC. This was particularly important when the early attempt at “co-management” stumbled, and it is heard in the comments of BPMC leadership committed to making their partnership stronger. One facilitator who worked with BPMC described its Partnership as having a “*pioneer spirit*.” This spirit is reflected in both a determination to make Partnership work, and an interest in enabling it to work for others by generating “best practice” material.

The unifying urgency of the initial joint effort to open the Hospital, and the resources applied to making it successful, has not been replicated. While the link between performance pay and attendance, workplace safety and service goals has provided some degree of urgency, the ongoing nature of these goals, and the fact that they are ultimately measured at the service (rather than medical center) level, does not allow the same sense of accomplishment that comes with definitively completing a high visibility project. Projects without any external, high priority operational deadlines or dedicated support are vulnerable to being interrupted.

One of the notable aspects of the BPMC story is the attention since 2000 to building a foundation for Partnership throughout the Medical Center and designing systems and programs that can allow it to flourish. Among the examples of this attention reported in the prior pages are the emphasis on training, designing the Buddy system to develop new union leadership, producing the attendance toolkit to be used facility-wide, and creating Department Based Teams throughout the Medical Center.

The DBT initiative is a particularly ambitious example of BPMC Partnership’s systematic approach. This initiative is aimed at bringing partnership to the facility’s front lines, and it has succeeded in involving over 350 people working regularly on operational and strategic Partnership activities. This amounts to an investment in DBT meetings of thousands of person hours each year (in addition to the substantial time spent in meetings of the Steering Committee, team projects and service area/regional Partnership activities, preparing for meetings and any follow-up that they require). As the Partnership looks to realizing a return on this significant investment in the years ahead, the ability to accomplish this would be advanced by attention to the following points:

- The extensive training completed by management and labor has created a general understanding of partnership principals, but it has not equipped the front line leadership (management and union) being called upon to co-

chair the DBTs with the skills and support that they need. The generic training programs developed for the Partnership have limited effectiveness in building skills and do not provide support for reinforcing and strengthening skills as they are practiced. In general, training that is not connected with actual collaborative activities, and not reinforced after experience, has limited value. More skillful meeting management and facilitation in the DBT meetings would increase the value derived from these meetings, potentially develop the skills of rank and file members as they experience participating in effective activities, and diminish management domination. The lack of training support for the DBT co-chairs (managers as well as labor) to develop these skills echoes the failure to adequately train the earlier co-leaders. A combination of targeted training and peer support forums would be one way to fill the gap. For the Partnership to produce substantive results, and to avoid the frustration that builds up when people believe that meetings are not worth their time, better training in generic team leadership and management skills will be needed. Given the number of DBT co-chairs leading meetings at Baldwin Park, consideration should be given to bringing this group together for training, followed by periodic opportunities to meet as a group to reinforce the training and learn from each other's experiences.

- As the numbers and time investment of individuals involved in Partnership activities increase, the challenge of completing the Medical Center's front line work increases as well. This creates stress on the managers and union members who are trying to do both, and on the others in the departments who are expected to absorb additional work while their colleagues are attending to Partnership responsibilities. Dedicated resources make a difference. The Labor Liaison positions created in 2000 have provided a structure for enabling UNAC and Local 399 participation. The Building on Excellence initiative illustrates the value-added by a designated "project manager" function. More generally, backfill is a problem throughout the KP Partnership that becomes even more acute as more people are engaged in Partnership activities.
- The capacity to track outcomes needs to be better developed – identifying the data to be collected and supporting gathering and reporting it in a useful format. This is not something that can be accomplished at the facility level alone. The confusion observed at BPMC over interpreting the different service scores, as managers and union members attempted to track performance against goals, consumed time that could have been more profitably directed to engaging on service improvements.
- The number of DBTs at BPMC, and the variations among them (for example, in membership makeup), could serve as a laboratory to understand how to maximize the effectiveness of bringing partnership to the front lines. The Steering Committee's project to assess the DBTs has the potential to produce some comparative information, if it is completed.

Analyzing People Pulse scores at the Department level would provide an additional tool.

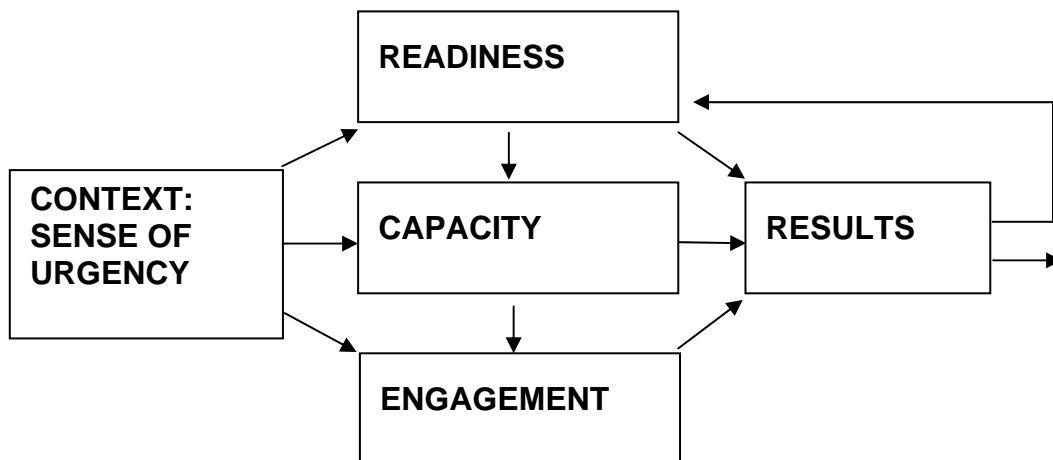
The fact that the DBT assessment project was interrupted by other demands on the Steering Committee is symptomatic of the Partnership undertaking activities beyond its capacity, and of conflicting directives that deter completing activities underway. This is certainly not unique to BPMC. Minimizing this through more realistic planning about resources and priorities, and high level commitment to follow-through on Partnership activities undertaken, is important since confidence is undermined when there is failure to follow-through on activities that are started. Among the lessons learned from the BPMC experience is the role of confidence in the partnership strategy as an element that sustains individual as well as institutional commitment to making Partnership work

## APPENDIX A: Framework Analyzing Partnership Projects

**(Excerpt from Kochan, et. al, The Labor Management Partnership at KP: 2002-2004, pp. 7-8 (Work In Progress)).**

Figure 3 summarizes the framework we use to analyze Partnership activities and to structure the body of this report. It is based on well established theories of organizational change from the behavioral sciences and labor management relations<sup>5</sup> and uses the language and strategies Kaiser Permanente leaders draw on in implementing the Partnership. We will start by reviewing the context in which Partnership activities are situated, focusing primarily on the degree of urgency or crisis that motivates the project. Then we will analyze the structures and processes used to design and implement projects by drawing on the Partnership terms of readiness, capacity, and engagement. Finally we will draw on the best data available to report the results of the activity, both in terms of specific substantive results and their effects on on-going relationships, learning, and diffusion of partnership behaviors and principles. In using this model we will give special focus to “pivotal events” or challenges parties inevitably encounter in partnerships like this and discuss how they have been addressed, and their effects on the Partnership.

**Figure 3: Heuristic model of LMP**



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