

ASSESSING THE PARTNERSHIP AT NAPA/SOLANO



I W E R

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INTRODUCTION

This overview, and a focused case study on the cost reduction initiative in the clinics, report on fieldwork conducted during July 2003, together with follow-up visits in December 2003 and August 2004 that examined the Partnership in practice for the Napa/Solano service area.

To what extent can this case study provide an assessment? Only partially. Systematic hard data are not yet available. This roundup includes the perspectives of the participants and provides information about the process of engagement. Given the reality that the Partnership is a “work in progress” this study should be seen as a snap shot.

While I was on location, I conducted extensive interviews with members of management, union officials, and rank-and-file workers. Most importantly, I was able to attend a range of meetings, including the monthly Partnership meeting at the Vacaville satellite facility, the monthly Partnership meeting of the Chemical Dependency Department at Vallejo, the monthly meeting of the Supply/Cost Working Group at Vallejo, and the monthly stewards’ meeting.

BACKGROUND

The service area known as Napa/Solano serves 240,000 patients in four clinics and a hospital. The size of the staff approaches 3000 employees. In many ways Napa/Solano is representative of the 18 other medical centers in California. Consequently taking the measure of the Partnership in this service area provides some insights into whether and how the Partnership is making a difference “on the ground” on a day-to-day basis.

An organizational unit as large and complex as the Napa/Solano service area presents formidable challenges in determining the impact of the Partnership. The approach taken here is to take the measure of the Partnership by using a variety of perspectives. One logical entry point is by location, and some of the discussion will be organized around the three satellite locations, Napa, Vacaville and Fairfield. Another cut is by department, and observations will be presented about the hospital and several of its major clinics in Vallejo. Further, it

is possible to assess the Partnership by analyzing the roles played by the major “actors,” especially management and union leaders. Finally, consistent with the approach being followed throughout our case studies—it is important to analyze a number of cross cutting themes, such as attendance, safety, and the transition to computer record keeping, i.e. the installation of Health Connect.

Structure of Partnership Meetings and Forums

If measured by the number and variety of regular meetings, clearly the Partnership is up and running. Formal labor-management committees have been established for the service area (referred to as the Napa/Solano Labor Management Partnership Steering Council); at each of the satellites—Napa, Vacaville, and Fairfield; at the departmental level (primarily Vallejo); as well as launching a number of task forces/working groups (e.g., the cost-reduction effort for the clinics that has spawned 15 subcommittees – to be discussed).

At one of its monthly meetings, the Partnership Steering Council reviewed a detailed document outlining the charter for the labor-management partnership. This document laid out norms, responsibilities for sponsors, communications, responsibilities of facilitators, and responsibilities of committee members. Under the “Purposes” part of the document, there were fifteen bullets. Clearly, the parties have given considerable thought to establishing ground rules for the partnership.

Management Capacity

The Napa/Solano service presents many examples of how important management capacity is in achieving effective partnership engagement. Best practice examples are present as well as examples of where—in the words of a union representation—*“management just does not get it.”*

The Chart Room manager has an outstanding record. She is responsible for over 90 employees located across the four sites. Some might say her style is that of a “mother hen,” but regardless of the label, it is extremely effective. Let’s hear from her directly:

I get asked a lot: “What do you do differently? How did you learn this?” I don’t know. I worked in the Chart Room long enough, and I worked with a boss that was a dictator in many ways. She would come in, slam things down, she would yell, scream, accuse. And I know how much I hated that. I don’t want to be told that I’m not working, knowing that I HAVE worked. I find it much better, if you have doubts about someone working or not, walk up to them, engage them in conversation— “What are you doing?” and that works.

Five years ago, you’d walk in, if somebody didn’t say “This is what we’re going to do,” they’d all stand there and say, “We don’t have any direction, we don’t know which direction to go.” Now, it doesn’t happen. They do the assignments. It could be a file clerk with 5 years in the department telling someone who’s been there for 30 years, “OK, you need to cover the telephones, and you’re going to do this.” And everyone will buy into it. It really is empowerment. If you get the staff involved, they feel they have a say, and they are more willing to deal with the situation.

It’s important to keep track of work/life balance. I understand that my employees are going to be sick and that their kids are going to be sick. It only makes matters worse if I stress them out. Recently I attended a meeting of management where there was a discussion about disciplining a person for attending her best friend’s funeral. The whole discussion was very negative. I would never prevent anyone from going to a funeral. I work with my employees so they do not feel the need to lie to me about things. They tell me the truth.

Another manager, who exhibits an exemplary style, is the department head for Pediatrics.

Much of the explanation for the strong working relationship in Pediatrics rests with the style of this department manager. She has delegated to her assistants responsibility, for the three satellite facilities, enabling her to concentrate on the large clinics at Vallejo. She is very forthright in her approach to members of the department, reflecting: *“If I have made a mistake, I admit it right away, thereby avoiding a grievance.”*

She can be seen as a risk-taker, having pushed through the idea of one medical assistant to one pediatrician, which could have increased costs. However, in fact, it has lowered costs since with the attachment of one medical assistant to each pediatrician, there is much less absenteeism and much higher productivity.

The Pediatrics Department is now in what might be thought of as a “steady-state” mode. The twice-a-month meetings now take place once a month.

One of the key factors for continuity is the stability of the leadership at the top of the department. Since starting with the Partnership in 2001, the same physician-in-chief has been in office and has played an active role in the governance of the Partnership.

Lack of involvement in the Partnership on the part of physicians is often mentioned as a problem. At Napa/Solano, however, a pathologist serves on the Partnership Steering Committee and has played a key role in his own department (the laboratory) as well as helping other departments move ahead with Partnership projects. Here he discusses how he first dealt with an accumulation of problems:

When I got involved there was a litany of grievances against the laboratory from Local 250. And the reason -. My lab manager hated the union and fought it tooth and nail. I went in and in one session cleared out all the grievances and started from there and realized that the only way to move forward and get things done is to work within a cooperative, partnership manner with the people. So we built an informal framework and then formalized it a couple years later with the formation of the Labor Management Partnership Steering Committee for the laboratory.

With respect to how he behaves in meetings and how he helped another department (pharmacy):

We established a labor/management Partnership steering committee with the pharmacy. And when people at meetings start finger pointing and saying, "Well, I don't trust management" or something, I cut it off. Or when management says, "I don't trust the union", I say, "Cut it off." We have to begin on an open basis. So because of the relationship I had built up within the laboratory, people believed me in the pharmacy, and we immediately started moving forward and effected some dramatic changes. I could go to the head of the pharmacy and tell him that his managers were beating up on the employees and that they weren't doing a good job. So we made some dramatic improvements in the relations there.

The important test for the Partnership is whether it helps managers who are not naturally inclined to share power to develop and to learn. Here is an example of one department manager who is beginning to "see the light":

Because my style is so directive, I started to wonder what on earth is going on. I've had it said to me, "You're really need to do more to

develop relationship and for them to like you. Because for some reason they don't." That's hard to take. I cannot work like I want in the Partnership. I can't make decisions. When I give a directive, it's perceived as being autocratic. For a long time, I didn't know what to do. I think I'm doing better as a partner now because I am beginning to understand.

Despite these positive examples, however, many managers are seen as still operating in a very traditional mode. Training programs are being put in place, such as Managing in a Partnership Environment, and steadily managers who "do not get it" are being replaced. Consider these examples:

We actually had a physician, a department head physician, with some real problems. Two of her LPNs both filed claims against her, harassment claims, saying she had made some very disparaging comments in a published letter about unionism and the Partnership. Anyway, she was gone very shortly after that. (Steward)

In another instance that surfaced at the stewards' meeting I attended:

The steward from the Communications Department reported that she had continued to file grievances about her supervisor who was a real problem, and she sent these up the line. Then all of a sudden one day, her office was empty.

The process of aligning management, including removing individuals who are not working well with the Partnership, has both positive and negative sides. With respect to the positive, the physician in charge of the clinics commented:

We need to make changes. We've had the Vacaville medicine manager resign. Fairfield medicine manager wasn't working out, so we moved that person to another facility. And we've had a key manager here in Vallejo just resign.

For the challenges posed by leadership changes for the development of the Partnership, Roy Clarke, the facilitator, observes:

With all the change in leadership, both within Kaiser management and the union, this sometimes forces us to start back at square one. And I think that's been one of the main obstacles facing the Partnership here in Napa/Solano. These changes slow us down in getting the Partnership down to the front-line folks.

An important development is the willingness of the union to have members designated as “leads” for departments. Rather than having a member of management or a charge nurse as head, members of Local 250 are now willing to work for other members of Local 250 who hold quasi-management positions. This is obviously a by-product of the better relationship stemming from the Partnership.

Union Capacity

Napa/Solano provides a representative picture of the challenges facing the union as it responds to the demands and opportunities of the Partnership. Attitudes regarding the Partnership among union leadership vary across a wide spectrum, especially for stewards. Here is the profile as seen by a seasoned service representative:

You have stewards who are absolutely fundamentally opposed to the Partnership. And whether we'll ever be able to change that or not, I don't know.

And then you have the group that is very active with the Partnership, who are on every LMP Committee you can think of, who are involved in not only their departments but regionally. They have embraced the Partnership and are beginning to work it in such a way to benefit the membership and see that this really is a way to make change in the workplace and it really can create a better work environment if we put the effort into it to make it happen. And we can't rely on Kaiser to make it happen. We can't rely on some manager to make it happen. A lot of the seasoned stewards have the same goal I do: they just want things to run smooth; they want to be able to come to work every day, get 8 hours of pay for 8 hours of work, and do it on a nice level, without any stress or added drama for the day.

And then there are those who are extremely new to the process, who are just starting to get their fingers into it. I think they have a lot of potential as far as what they will accomplish in the future. They really don't have the concept of partnership yet. They have a lot of problems with the front-line managers and they are becoming stewards because they want to fix this right now. And that's good, though, because then they have the opportunity to learn the whole big picture. They will reach beyond us and make it grow even further. I think that's an exciting piece to watch develop, because they will certainly see it in a different light than the old folks like me who have been around forever.

When I first heard about the Partnership years ago. I was like, “Oh my gosh, what are we doing??” But I’ve seen good things come out of it.

Increasing the Number and Readiness of Stewards

All of the unions involved in the partnership have insisted that all partnership meetings and working groups have union representatives present. This has required a substantial increase in the number of stewards. For the segment of the workforce represented by Local 250, the number of stewards has almost doubled, from 30 to 54 individuals.

The next step is training. A seasoned chief steward comments: *“These stewards are not college-educated, and they’re meeting college-educated managers and they’re overwhelmed. So we need to take these people’s skills up a notch and I’m trying to do a lot of that.”*

The facilitator commented about the readiness of union representatives to participate in partnership meetings:

I have found that some stewards feel inadequate, and they don’t know what to say when they go into meetings, and they don’t know how to run a meeting. So what happens often is that managers who feel more comfortable leading take the lead, and then the stewards leave the meeting saying that their agendas were not met.

In addition to formal training, the leadership of Local 250 brings representatives from each of the facilities in northern California into Oakland every two months. Each facility sends two delegates, and at this meeting the union president provides an overview of developments and issues stemming from the Partnership.

Challenges Facing Union Leadership

The interviews revealed a range of issues confronting stewards in balancing their roles as providers of healthcare with their roles in the Partnership.

Difficulties in Finding Time to Attend Meetings

It's always been my philosophy that patients come first. If I were to go to meetings and leave my co-workers covering my load, they would get tired of it very quickly and it's not fair. (Vallejo steward)

I work in OB and I just can't leave and say, "See ya!" The doctor has to have a nurse with him. (Napa steward)

Backfilling Presents Challenges

If they can't backfill it, we don't go. I've missed two meetings lately because they couldn't backfill me. I have two voicemails that I have to pick up so those don't get answered. So I come back from my meeting and sometimes I'm here until 7:00 p.m. doing that stuff.

And actually, the backfill that I get, they are good nurses and I'm not worried that the patients aren't going to be treated right, but that's all they can do. They can't do any of the work that has to be done on the computer or anything. (Napa steward)

These issues are well summarized by a business agent for Local 535 who covers large portions of East Bay:

It's hard for people who have a full schedule of commitments to make time for meetings. It usually requires professionals to have a six-week lead-time if they are going to spend any time away and participate in the Partnership process. When a steward is participating, it is very difficult to backfill because patients feel uncomfortable interacting with them in the delivery of services. Then there's a pushback from colleagues who wonder why the steward was allowed to go to a meeting and ended up creating an extra workload for them.

Given budget pressures and restrictions for the use of "on call" personnel, the creation of a fund to finance backfilling has been a priority.

And this has actually been talked about at the national level and among the Partnership – how we deal with making sure that departments are staffed appropriately so that people can get released to do the Partnership meetings they have, whether they be cost-savings meetings, or budget meetings, or just plain labor-management steering committees or departmental meetings, whatever. And there has been some commitment on the national level that there is going to be a special fund, so the money to pay for their release time to go to these meetings is going to come out of that. So the individual department doesn't have to carry the price of paying for me. (Chief steward)

However, at the Napa/Solano service area, the funds were either not available or were not being utilized.

Finding Time to Connect with Union Members

Even when stewards have unscheduled times, they often find it difficult to have a meaningful interaction with members e.g. reporting on what has happened in various partnership meetings:

I find it very difficult to walk into the departments and get a chance to actually talk with the staff. They are just SO busy with patients. And it certainly is inappropriate for me to walk in there and interfere, or cause a delay in the delivery of care. So I'm very conscious about trying to make sure what they're doing before I have discussions with them.

But it does get very difficult to have those small group discussions with them about what the Partnership has done, what the Partnership is working on, what are our goals for the year or next year, and how we see us getting there. It's very hard to do that. (Napa/Solano steward)

Scorecard for Union Capacity

Developing the capacity necessary for the union to play an effective role in the Partnership is a work in progress.

When I visited Napa/Solano during the summer of 2003, I attended the monthly Local 250 stewards meeting. Both the chief steward and business agent exhibited very effective leadership styles. During the meeting, as stewards presented problems, the leaders committed themselves to meet with the managers involved. In some cases, they asked the stewards to collect more data. They remained sensitive to the core requirements for union leadership, that is, protecting the interests of members—for example, whether on-call workers were taking work away from bargaining unit members. To reinforce this, the chief steward commented, *“The budget does not override the contract.”*

At the same time, it was clear that they were strongly committed to the Partnership. This view was affirmed by Dr. Nathan: *“The chief steward has been instrumental in moving forward and effecting change here [Vallejo], especially in the Medicine Department.”*

When I visited Napa/Solano one year later during the summer of 2004, however, the leadership picture had changed dramatically. The chief steward had resigned and been replaced by four “chief” stewards serving as a team. Monthly meetings of the stewards were being chaired by the new servicing representative (the third person in this role in twelve months). Commenting on this, stewards observed that the affairs of union members should be in the hands of local leadership: *“The power shouldn’t be with the servicing rep. The power should be with the stewards.”*

The view from Oakland, however, struck a different chord. Leadership at the top level of Local 250 observed that some local leaders might be unwittingly only serving the agenda of management. So what might be seen at the local level as a constructive initiative, e.g., designing a program to deal with absenteeism, might be viewed by full-time union officials as doing management’s bidding.

Turnover of key union leaders clearly can make the journey toward a robust partnership more difficult. However, in some instances, the turnover of union leadership, especially at the business agent level, can be a step in a positive direction. For example, the business agent who attended the Summer 2003 meeting at Vacaville caught me after the meeting and said he was being transferred to another part of Local 250. This business agent, who used rough language in his dealings with managers, many of them women, was transferred after the physician in charge called the president of Local 250. In commenting on this episode the physician in charge said he hoped business agents assigned to Napa/Solano would have grown up within Kaiser, thereby appreciating the unique features of the organization as well as having experience with the Partnership. (Since Local 250 represents many employees who work for other organizations in the health field, many business agents who may be assigned to Kaiser most likely will only have experienced traditional, adversarial relationships.)

Engagement

The parties have committed themselves to embedding the Partnership into day-to-day operations, what is referred to as “engagement.” For engagement to have a chance to make a difference, a structure of committees and other organizational arrangements need to be in place to enable the parties to deliver better outcomes. Strong leadership, as discussed earlier, is also essential. The weight placed on structure versus leadership varies. In my meeting with the Partnership co-chairs in Respiratory Therapy, the manager emphasized the importance of structure: *“I think a formalized group is a necessity. We meet on a monthly basis. We have a structure in place where we can come together and formalize our agreements, which I think is necessary.”* Her counterpart, the union steward, expressed his preference for the role of leadership and process separate from structure: *“To me, it’s the people that make the difference, not the structure.”*

The union steward clearly places heavy emphasis on getting the right people in place, and he cited the use of a petition by the employees, which succeeded in replacing the previous manager. For him structure is not necessary if good management is in place with responsible union leaders ready to engage.

By contrast, the department manager, with her strong background in quality assurance and a deep knowledge about the tools that make for improving quality, emphasizes the importance of structure, i.e. having meetings, follow-through on tasks that get assigned at meetings, and being systematic in identifying problems and implementing solutions.

Ultimately, the litmus test for engagement is whether the Partnership makes a difference for the average employee. One steward commented that for many years the Partnership had only been leaders of Kaiser (the management) having lunch with leaders of Local 250. Succinctly stated: *“It’s been a partnership of the leaders, not a partnership with the staff.”* With the expanding number of stewards and the creation of various partnership committees and forums, engagement is increasingly occurring at the grass-roots level.

The chief steward at Vallejo gives another example:

Hopefully these department work groups on the clinic side, where the employees are able to work through these budget issues and come

up with cost savings, hopefully they see the results of the Partnership as good for them, such as closure the day before the 4th of July. That was a win/win for everybody. Those types of things, for those employees, make the Partnership come alive.

However, for many parts of the organization, engagement is not yet robust. The experience of the OB/Gyn department illustrates the learning journey. Early on this department formed a Labor-Management Partnership Committee, and the members received three days of training in the tools of the Partnership. The committee then developed a series of options for restructuring duties and assignments. However, when it came time to implement these ideas, with the union representatives insisting that more staff be added, management pulled back and terminated the effort. As a result, for several years partnership activities were on hold. However, as of 2004, the OB/Gyn department is back on track, in large part due to the change in outlook and style on the part of the department manager.

An Example of Successful Engagement

In addition to structure and leadership, effective engagement requires process skills, with the parties working together to solve problems and improve the delivery of medical care on a cost-effective basis as well as enhancing the employment experience for all stakeholders. The ultimate test of engagement is achieving a better set of outcomes, and answering the question whether the Partnership can be given credit for these changes.

The Pediatric Department briefly noted earlier is an example. When the Partnership took hold in the late 1990s, it was clear that Pediatrics would be one of the first departments targeted, because of its problems, to receive training and to have a committee formed. As one of the stewards made the point: *“We had lots of communication problems in the department, low morale, a lot of inner turmoil, and there was no quick fix, no way to resolve these issues.”*

The Joint Labor-Management Partnership Committee, formed in 2001, consisted of ten individuals: 6 support staff, the physician in charge, the department manager and assistant manager, and one other member of

management. Independent facilitation was provided; however, as the stewards commented, *“We went through three different facilitators.”*

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

This involvement of a substantial number of individuals from the department contributed to the success of the project:

The different projects helped bring everybody in, so everybody felt they were part of the decision-making process in the department. Because before, a lot of things were handed-down orders as opposed to our being part of the whole decision-making process within the department. So by forming the committees, everybody felt they were part of the department. We have a great group of people who work there; it's just that over time the way decisions were made, we never felt a part of anything. This way everybody felt they were a part, those who wanted to be, by being on the committees. (Stewards)

Turning to concrete changes, the following details the substantive outcomes from the work of the Partnership committees in Pediatrics:

For instance, the workflow committee. In our department we had gone from 1-1.5 to a 2-1 ratio – 2 doctors to one MA. And that kind of broke the morale. I mean they work very hard and very fast paced in our department, and one of the things we decided in the LMP committee was that we could figure out a way to become one- on- one, one doctor to one medical assistant, which helped morale from the beginning because that's something everybody had wanted for a long time anyway, but we were always told that it couldn't happen. But once our physician in charge got on board to figure out a way to make this happen, the workflow committee went forth to do this.

And so we had to break it down into tasks, what things needed to be done. We did it in like a flow chart, each step of it, and figured out how this was possible. And with the staff we had, we could take some people out of individual jobs like telephone and put them into the mix and train everybody. (department manager)

Keeping everyone in the department informed takes place in a variety of ways. One important forum is the departmental meetings that take place every month to update all members of the department on what the various Partnership committees are doing. Also, since everyone in the department knows who is on the LMP Committee, they can seek them out for additional information about the work of the committees.

In my interviews with members of the department, the issue of trust was frequently identified as a critical feature of the journey. Consider this comment:

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

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

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

In answer to the interview question: How do members of the department feel about the Partnership program: *"Oh they like it. So much easier. You don't have the issues. You work together instead of having 'I want it done this way, No, we're going to do it this way' type of system. Just easier. Saves time. The morale is better. Trust. Everything."* (Stewards)

One of the encouraging developments for the future of the Partnership, especially at the grass-roots level, is the availability of a full-time facilitator, Roy Clarke, who has established a working relationship with many of the departmental committees, as well as helping to solve some of the start up problems at the satellites, especially Vacaville and Fairfield.

Crosscutting Themes

Safety

Safety as a priority is coming into focus. As Dr. Stricker points out, *“Kaiser Permanente in northern California has a higher injury rate than any factory in the state. Ours here in Napa/Solano is terrible, and contributes to a high degree of absenteeism because people are injured on the job.”*

But progress is happening. Lift teams have trained personnel in methods for handling overweight patients. Earlier the managerial style of the Chart Room was cited – as a way of reducing worker comp costs workers are encouraged to stretch and do exercises that thwart serious injuries.

And equally important: the overall Partnership steering committee for the service area spends considerable time on the subject of safety. Here is an example from the March 2004 meeting: *“We need to move the Workplace Safety Initiative from an optional process to something that is mandatory.”*

Turning to specific outcomes, the Chart Room has exhibited an impressive record with respect to injuries. Employees in chart rooms are often subject to back and arm sprains from carrying heavy file folders from point to point. As a result of the Partnership and the good working relations in the Chart Room, over the past four years the number of injuries has dropped from 23 to 22 to 13 and down to 7 in 2002. As of August 2003 when I was on location, only one injury had been recorded. And when I visited the department again in August 2004, the corresponding number was zero injuries.

Economizing on Non-Labor Costs

In any organization a promising area for bringing employees and management together in a common effort is to find ways to reduce waste and to economize on supplies. No jobs are lost, and in the vernacular, it could be

considered a win-win. The best example for Napa/Solano is the Supply Cost Initiative Working Group.

Several points are important to highlight. First, the taskforce is co-chaired by a representative from Local 250 as well as two managers, one from the hospital side and the other from the clinic side. As a way of involving the nurses on the hospital side, the program is not referred to as a Partnership activity but instead as a constructive way to reduce costs.

One of the programs initiated by the Supply Cost group is referred to as “Cost Busters.” Each person submitting a suggestion that saves on supplies and other non-labor items receives \$5.00, and at the end of the year the best suggestion receives an even larger award. This program enables employees in the Supply Department to go beyond their normal role of ordering supplies and to lead a program emphasizing conservation.

Absenteeism

Vallejo has one of the highest absenteeism rates in the country, according to Dr. Nathan. This issue is receiving attention across Kaiser and has been an agenda item for the Napa/Solano Steering Committee at almost every monthly meeting.

Several managers attribute the high level of absenteeism to the culture of today’s workforce, which feels that it is “owed” some relief given the intensity of work.

My staff thinks that sick time is a benefit and it is not. I have a couple of people in my department who flat out tell me, “I’m going to call in sick for two days,” because on the third day they have to get a doctor’s note. But they don’t do it often enough for me to discipline them. I tried the approach of a graph. I wanted my people to see the record every quarter. It didn’t make any difference. (Department manager)

Individual managers, such as the department head in the Chart Room, can make a difference with their sensitive, what might be termed, “clinical” approach to employees and their needs. And the chief steward on the hospital side has developed a program that has been piloted in his department and is in the

process of being rolled out across the service area (see Appendix A for a copy of this program). Here he outlines the key features:

At times we've had an immense problem with absenteeism. A little while ago, we had 10 people out of 25 call in to the business office one day to be out of work. This meant that the 15 people who came to work had a lot of work to do, and it's impossible to find replacements for everybody. It's just not fair to the employees who come to work. Our role as the union is to represent the ones who come to work, and at the same time make sure the ones who do not come to work get due process. So I think a good attendance policy benefits everyone.

The essence of the program is that somebody has to be accountable, and this should be management. The program lays responsibility on management to be accountable for their organization and attendance.

Let me give you an example. We had a girl in our department who would call in every other Thursday or Friday and say she could not make it to work. Nobody said anything to her. My view is that all that needs to be done is for management to step in and say, "Hey, look, what can we do? Do we need to change your schedule? Can we do it within the guidelines of the contract?"

A good manager does not wait for three months. It's impossible to have a formula to fit all situations, but a good manager knows his people and can solve the problems that lead to absenteeism.

Health Connect

The changeover from paper to electronic record keeping will be a major development through out all of Kaiser. The thinking and the preliminary planning that is taking place in Napa/Solano offers a good look into the magnitude of the change and the steps that are being taken to make the changeover as smooth as possible for everyone concerned.

The estimates for the Chart Rooms at Napa/Solano is that the employment numbers, which are in the range of 90, will be reduced to about 7 or 8 positions. The transition will take place in the third quarter of 2006. Considerable planning is under way, and the manager of the Chart Room has attended several meetings with other chart room managers in northern California. These meeting usually take place in Oakland and serve to brief the managers on the new system. One of the immediate issues is how to help people prepare themselves for transfer to other areas of the hospital. To quote the manager: "*What I tell them is*

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

Over the three-month period preceding August 2004, twelve people had left the department for other positions in anticipation of the big change. The challenge, then, for the department is to fill these openings during the interim period. In view of the fact that caregivers are being phased out on the hospital side, some of them have decided to transfer in, even with the knowledge that within another two years they will have to transfer to other openings. How the department juggles both the short- and long-term requirements is captured in this comment: *“Recently we were talking about positions and openings, and how we would use seniority for all of this. There was one position that we agreed not to fill, and we would place it in the on-call category, and that person would help fill temporary vacancies.”(Manager, Chart Room)*

The impact of Health Connect on management is palpable. After returning from one of these sessions when she learned about the magnitude of the change, the manager recalled these thoughts: *“Recently, I went to one of these meetings, and they were talking so far above me. It was so technical that I said, ‘OK, you guys have your meeting, just let me have the final numbers.’ I was actually stressed the next day. So I immediately came back and said to my people, ‘We have to talk about all this.’”*

Finally, as an indication of this Chart Room manager’s dedication, consider this: *“Recently I was approached by my manager who said that I should apply for an opening that would involve a promotion. I said that if I did that, you will have trouble because my staff will say, ‘Job security nothing! If our manager is saving herself, then we need to save ourselves.’ So I declined to explore the new job possibility.*

Collecting Dollars at the Point of Service

Until recently, the model of care for Kaiser has been full service with no co-payments or deductibles. George Halvorson, CEO of Kaiser Health Plan mentioned in an interview that in the future 15-20% of the revenues for Kaiser will come from collection of fees for services. Dr. Nathan elaborated on the

implications: *“We are going to be a fee-for-service medicine program, and we have to change the mindset of our employees to work in this new service model.”* However, in Dr. Nathan’s view, they have only started the process of helping employees think about the changed behavior that will be required in the new paradigm.

Staffing

The cost-reduction program on the clinic side at Napa/Solano has involved considerable attention to staffing, holding positions open, rearranging hours worked per week, and in general avoiding the use of on-call workers and overtime. The savings have been substantial, meeting the target of \$10 million on an annual basis. This initiative is presented in Appendix B.

One indication of the significance of this program is that it has been “showcased” in several presentations. Tony Gately, administrator for Permanente in Northern California, presented the story to the regional presidents. And at the national FMCS conference held in Chicago in May 2004, key members from management and labor presented the cost reduction story. And on the basis of the successful experience with cost reduction at Napa/Solano, Dr. Robby Pearl, Permanent head for Northern California has asked other service areas to develop program for reducing costs and increasing employment flexibility.

Some of the challenges inevitably encountered when staffing is on the agenda are highlighted by the union leadership at the Napa clinic:

We're finding that management sometimes doesn't have a really good concept of how work needs to be done at the floor level. They may say you can do it with three people, when in reality you need five. So we have some disagreements on where we can cut the budget and where we can't.

We think the main concern should be: how do you treat patients? And sometimes they're only looking at the dollar signs.

And we have some disagreement on where they should cut. We think they should cut in the management area, and they think we should cut in the Local 250 area.

The problem is, when you try to cut people off of a floor, things aren't consistent. This isn't an assembly line, it's not an auto plant that you can crank out so many things every day, and you know what you're going to do. Here, every day is different on the floor. The doctors change, the provider numbers change by the day because some of them go to surgery, some of them are on-call, so you don't have consistent provider staff to have a consistent support staff. And I just don't think they understand that.

On the hospital side, not much has happened in the area of staffing, largely because the California Nurses Association (CNA) (a key part of the workforce, especially in hospitals) is not a party to the Partnership.

Outcomes

Hard measures of how the Partnership is making a difference are hard to come by. However, in a survey conducted in June 2004, a question was asked: How many departments do you have in the service area and how many of the departments are engaged in Partnership activity? The respective numbers for the two questions were 201 and 28, suggesting a low penetration for the Partnership—at least in terms of formal committees at the department level. On the other hand several managers who have a broad perspective estimated higher numbers, approaching 50%. Dr. Robbie Pearl, head physician for northern California described the performance of Napa/Solano as falling in the lower range for northern California but steadily improving. Several items contained in the People Pulse survey corroborate this conclusion. For example, on the question, “How much do you know about the labor-management partnership?” Napa/Solano stood at 41% and Vallejo at 38%, placing them at the bottom when these numbers are ranked for all service areas in northern California.

Turning to indirect measures of worker satisfaction – of course, difficult to link directly to the Partnership– it is clear that grievance activity has dropped considerably, to the point where it is virtually nonexistent. This is confirmed by

the comment of a steward at Vallejo: *“Since the Partnership, I can say I have not seen one clear contract violation.”*

With respect to direct measures of worker satisfaction, a steady improvement has taken place throughout 2002 and 2003 as shown in the following table:

Percentage of employees reporting “Well Satisfied”		
	Q-1 and Q-2	Q-3 and Q-4
2002	69%	69%
2003	77%	80%

On the other side of the ledger are the comments of a seasoned observer:

When I said to the stewards, “It’s my impression that if we voted on the Partnership today, it would go in the dumper,” I think the majority of them shouted “Right on!” They’re frustrated; they don’t think management is on board. You see they want a silver bullet out of the Partnership to be able to shoot the manager! But also the simple frustration of having a discussion and then management saying, “I’m making an administrative decision and whatever you’re saying is bullshit.” They are frustrated because they don’t see managers as partnering. (Facilitator)

Overview of the Satellites

Napa

Roy Clarke, a full time facilitator for the Partnership at Napa/Solano, summarized the state of the Partnership and the relationship at the Napa satellite as follows:

At Napa, they have truly worked well together. My estimation is that it’s a fairly small clinic, so they have a family atmosphere. Everyone knows everyone else, whether it be physicians or the RNs. They started using a process called the Common Interest Forum. It was

a forum for management and labor to come together and talk about operational issues and what's affecting labor and what's affecting management. The Forum predates the Partnership. So when the Partnership came along, they just folded it into their existing relationship. You might say Napa was very fertile ground.

The Napa story reflects the influence of the good working relationship that existed prior to the onset of the Partnership - with the Partnership being able to build on this strong foundation. The stewards observed: *“After the 1986 strike, things were really bad. So management wanted to figure out how to restore the relationship. So they asked labor to be involved in the planning of the building, and we were placed on that committee. That led from one good thing to another.*

Vacaville

Vacaville is a satellite facility that is struggling. They have stepped up to the budget challenge, but at the time of my visit in July 2003 they were behind in meeting their target for cost reduction. Several comments made during the meeting also suggested that keeping positions unfilled had been influencing the quality of patient care.

On the positive side, this facility is making good progress with the safety program and has exceeded the target for employees to be trained and certified. Other positive signs reported at the monthly Partnership meeting included: the launching of a labor-management Partnership committee in the Pharmacy, and regular meetings of a labor-management subcommittee in Psychiatry.

With respect to union capacity, more stewards have been added and have been trained. However, it is not clear that the chief steward supports the Partnership. Roy Clarke noted:

As far as Vacaville is concerned, I led an intervention with the co-chairs of the Partnership. I think the issue there is more personality than anything else. The lead on the union side has a mindset as to how things should be, and to some extent it may be outdated. Then on the management side, the co-chair probably thinks the same way. So they often clash just based on their assumptions about how things should be

done. The big issue I'm working on is helping them speak together on important issues and not getting into a tangle every time. One of the things that I'm focused on is separating these two leaders and bringing others in and moving forward.

Fairfield

I have not visited Fairfield – thus, my observations draw on the comments of others. In 2003, the stewards sent a letter to the medical administrator, for Northern California. Dr. Robbie Pearl, highlighting a number of problems at the facility. One focus was on the OB/Gyn Department, and criticism of management for not engaging employees in Partnership activities. I asked Dr. Nathan, a pathologist, who serves on the overall Partnership committee for Napa/Solano about Fairfield: *“A big task in front of us is restarting the labor-management Partnership in Fairfield. The Partnership has been nonexistent, but we're ready to restart it. OB/Gyn has come around, and I think they're in much better shape.”*

Inhibiting Forces

As noted, the data from the People Pulse survey, engagement in Napa/Solano falls somewhere between 10 and 30%. So why has the Partnership thus far only engaged a limited number of employees? Several factors can be identified as inhibitors to more widespread engagement.

Misalignment of Partnership and Organizational Structures

A major challenge in aligning the Partnership with the organization is that the fact that the Partnership tends to be deployed on a site-specific basis. However, at least for Napa/Solano, the medical organization is not site-focused but focused around medical specialties and functions across the entire service area. The challenge this presents for the Partnership and for union representatives is reflected in comments made by the two stewards from Napa:

There are so many meetings and so many things to do and report back, that we can't do it in eight hours. Having to deal with so many different managers – instead of having two managers, we now have 10 or 11 different ones. This is because you have a manager over the OB

specialty across the four different facilities in Napa/Solano. Then this manager has two assistant managers. And you have the same organization for Pediatrics, Dermatology, Optometry and the like. Every tiny piece has a different manager. And this makes things difficult.

Absence of Planning and Weak Skills in Running Meetings

Clearly there is a need for better meeting management. This is well illustrated by comments from a steward at Vallejo:

I think the problem is this: every meeting we have is one of putting out a fire. There's no stability in having a meeting on one subject and carrying it through until it's finished and solved, and then go to the next. All these meetings, one after another, it's a big fire, and then an hour later you go to the next meeting. And it's another issue and nothing gets solved. And if you want to talk about budget, that's costly. It's always a crisis, and you have to drop your schedule, all of your work, to come to this meeting, and then you're behind on everything else and that becomes a crisis.

Another example of dysfunctional meetings – in this case poor management of the meeting by physicians:

In Medicine, they DO have department meetings, but they need to include the agenda of the workers, the front-line workers. Generally in these staff meetings, the agenda of the doctors is what happens. And what's sad is, they start talking to each other about whatever their agenda is, which has nothing to do with staff, the staff doesn't even understand, and during the whole meeting you're sitting there listening to them talk back and forth. And anything that should be addressed, could be addressed, or could be solved, or even a new idea to make something work really great, NEVER gets addressed because they are "on the timeframe, on the time limit." (Steward)

Power Sharing: a Learning Journey

One of the major challenges embedded in the Partnership, which has given the parties the most difficulty, is the subject of power sharing. We have already noted the differences in leadership styles between the Chart Room (with considerable delegation) and the OB/Gyn department where the department manager delegated the subject of work organization and staffing only to experience “a disaster,” since the recommendations that came back from the

working group could not be accepted, and the result was considerable recrimination.

Certainly, managers have concerns about power sharing:

There is the naïve believe about the Partnership that it means co-management. When we came back from a two-day training session, I kept saying to the steward, 'You need to learn—there's a lot that you have to learn.' She took that as elevating myself to a level that she couldn't attain. That was not my intent. (Department manager)

Another issue was also expressed by this department chair: *"The journey has been a rocky road because the union leaders expect that partnership means that management would give approval to everything the union brought forward."*

The facilitator who helped departmental committees commented:

One of the big problems is that the stewards often have a different definition of partnership than managers. To stewards, partnership means that the doctors, nurses, everyone should come and talk about issues. Stewards have been told that they are in a joint decision-making process and everything that's done should be done jointly. And for the most part, I don't think management sees it that way.

Clearly, the Partnership thrusts supervisors and rank-and-file employees into a new situation fraught with ambiguity as to whether decisions will be based on consensus or whether management will consult but reserve final authority.

When management operates in a traditional mode, they are accustomed to making decisions, with varying degrees of input from affected workers. With the Partnership, however, and the joint commitment to processes such as interest-based problem solving and consensus decision-making, managers may lack the necessary skills to maintain control and to move things ahead after adequate discussion.

Clearly, the consensus rule is proving challenging to the parties. It gives strong-minded individuals considerable leverage. The hope is that managers will learn to move beyond their comfort zone of traditional decision making, and the union participants in turn will learn that at some point a decision needs to be made and everyone needs to say, "Fine, let's support that decision and proceed."

Soft Fostering

Another challenge facing the Partnership in terms of day-to-day engagement is that too often the process resembles “soft fostering.” The parties meet and everything is amicable, but not very much else happens.

Several of the meetings I attended fell into this pattern. The parties spent time in coordination and attention to issues but often did not bring them to closure. In fact, at one departmental meeting, I noticed that subjects such as seniority, productivity, and weekend/ vacation scheduling were all labeled as “Tabled.” Moreover the physician in charge observed that important items needed to be addressed, and he enumerated communications, space, ergonomics, cleanliness, medical-legal issues, work schedules, hiring, budgeting, and the corrective action program (mentioned in the Master Agreement). But none of these high-priority items were discussed.

Further evidence for not tackling important topics can be seen in the response to a question to stewards from the Napa satellite about agendas for their monthly council meetings: *“We talk about how clean the building is. Do we need more housekeepers? We talk about new jobs that are coming up, or jobs that are being deleted. If a manager did something we didn’t like, we might talk about how to handle it better next time.”*

Some of the difficulty experienced in coming to grips with tough issues relates to the guidelines that were made in the Reaffirmation document of the Partnership about the qualities of discussion in meetings. Discussion should be direct, yet at the same time professional. One business agent (I saw him in action at Vacaville) knew how to be direct, but he was not professional in his approach. On the other hand, too often discussions are overly polite but not assertive enough in terms of digging into the problems and identifying the key interests of the various stakeholders. Achieving the right balance: the skill of being open and frank without being confrontational is difficult and often in short supply.

A Major Disconnect

As would be expected, the Partnership is a “non-starter” for CNA. The fact that nurses—especially central to delivery of medical care in the hospital and, to a lesser extent, in the clinics—are not part of the Partnership has created a number of obstacles hindering the effective functioning of the Partnership. Consider these examples:

- *At the Napa satellite the doctors wanted Fridays off. So they proceeded to shut OB/Gyn on Fridays on a permanent basis. Well, the nurses are members of CNA, they are not members of the Partnership, and so they didn't support it. So the two nurse/practitioners there are still working on Fridays, which defeats the whole thing. So one of the stumbling blocks to implementing across the medical center is the fact that we have non-Partner member unions. We wanted to do a major restructuring in the scheduling of the physicians and nurses in the Emergency Department, which accounted for 25% of cost overage within the budget, but it has been vehemently opposed by the CNA, to the extent that they have filed an unfair labor practice charge against us and are demanding reams of data and information before we can implement any changes in nursing schedules (stewards)*
- One of my interviewees speculated that the nurses who are not eligible to receive the performance dividend (potentially 2% if safety targets are met), might not be as motivated to take the lead on safety as members of unions covered by the national agreement.
- *In my department we need to use charge nurses in a very active leadership role. One of the first things I did when I came to this department was to get the charge nurses to actually function in that capacity. But when it came to the labor-management partnership, it didn't work to our advantage because we couldn't figure out how to include them in discussions. But how could we exclude them? We had a lot of heated and emotional discussion about whether they should be or not be at the table. [Department head]*

New Patterns of Interaction and Relationships

Perhaps the most impressive evidence that, despite all of the challenges, the Partnership is making a difference can be seen in the “opening up” of the organization. This involves both a better understanding for the challenges facing the organization, and access by union leaders and rank and file employees to key decision makers.

A Deeper Understanding of the Challenges Facing the Organization

This is best captured by a comment from a Napa steward: *“Now we have at least some idea of how the organization runs, which we never did before. We have some idea of what the budget is all about.”*

Several interviews illustrated the value of “opening the books”:

We have fewer numbers of patients, so we're not growing right now. So it's putting a real burden on all of healthcare. At some point, it's going to start hitting us pretty hard too if things don't turn around. From my understanding, we budgeted for a certain amount of growth and if we don't get that growth, those dollars don't come in, and then we're way over budget. (Shop steward, Vallejo)

And a comment by the manager of the Chart Room:

In the past, budgets have always been a secret. Managers closed their doors and discussed the budget. At our last meeting, I handed out a copy of the financials for the different departments to different people. So Napa had Napa's budget, a Fairfield person had Fairfield's. And they were able to go line by line and see where the dollars are spent, to the point where – I know it's a taboo thing, where people don't like to know what the managers are making – but if they wanted to do the math, they could figure out my salary. And we're able to better communicate to people, so when they keep saying, “I want, I want, I want...” I can say, “Well, this is what we have as far as the budget. This is where we're at.”

So right now, as we're having this crisis going on with Kaiser, financially, and hello, we're down 3 positions. And on-call, 4 positions. Just in Vallejo. But I'm not being harassed about it. People understand what's going on, it's communicated out, and it's shared.

Knowing How to Access the Management Organization

I was impressed by the many examples illustrating how union representatives have gotten to know who is who in the management hierarchy. Here is how one of the shop stewards at Vallejo expressed it: *“Before the Partnership, we only knew people in labor relations. As a result of the many meetings of the Partnership, we’ve gotten to know supervisors as well as department managers higher in the organization, and we don’t hesitate when we have a problem to go to the ‘higher ups.’”*

Another example was given in my interview with the shop stewards from Vallejo:

I’ll give you an example. They had closed off a reception area and put both the receptionists on one side. The people didn’t like it. Their ability to function in that manner was not there. And the patients didn’t like it.

So I asked the manager, “You know, this person needs to go back on the other side, it isn’t working, it’s creating lines, etc. etc.”

Well, she didn’t change it; She wasn’t going to change it, that was the end of the story.

I said OK, and I went to her boss and said, “Look, this is a hardworking person who worked over on this side. She’s willing to register for all the providers, just not to have to sit on that side. What can you do for this person?”

So she said, “Oh, that makes sense. Let me talk to the manager.”

So had we not had this [Partnership], we would have just had one grievance meeting after another until we finally got to the point where they would have had to change it because they would have had to see the logic in why it needed to go back.

Being able to take issues directly to key managers can also have the quality of “telling the emperor he/she has no clothes.” This newfound “power” was illustrated at the meeting of one departmental labor-management group that I attended. Early in the meeting, a professional spoke frankly to the physician in charge, saying that his behavior at a meeting the preceding week had been very disrespectful. Apparently what had happened was that meeting had been called to talk about allocation of space for the renovated facility. The facilitator asked the group to brainstorm and generate options. At some point, the physician in charge grew very frustrated with the process and walked out of the meeting. At the meeting I attended, the professional asked the physician in charge what he was

going to do about it. He immediately apologized for his behavior, and explained his frustration over what he saw as a very time-consuming process. He said that at the next meeting devoted to space, he would apologize to the full group.

A Roundup of Perspectives

Comments from three key leaders—a senior manager, a chief steward, and a consultant/facilitator—help us achieve some triangulation on how the Partnership is working in Napa/Solano.

Sandy Rusch (Chief Administrator for the clinics):

The Partnership had really not grabbed hold at Napa/Solano until the cost reduction mandate came into place. The Partnership had been tried at OB/Gyn with a focus on joint staffing, and as a result there, the relationship had deteriorated and members of the department were calling for the physician-in-chief to be replaced. The only bright spot until the cost reduction effort had been the progress made in Pediatrics, although this has taken 18 months to realize important gains.

Chief Steward:

It's a long road, and I don't know if we're halfway there? I don't know how to judge it either. I know where we came from; I know where I hope we're going. I certainly would not go backwards. But we definitely are not there yet. We still have a lot of work to do.

We have department that have actually been able to do something with it. As opposed to departments that are just hanging out there. They're not real bad, they're not real good, they haven't become part of the Partnership. Probably it's not real to them.

And then we have the departments that really have gotten a lot of attention but they're still very dysfunctional because either the support is not there to get them up and running, or their immediate manager is REALLY stalling the process. We've got some of that out there too.

Dorothy Christiansen (consultant and facilitator):

What has happened here is we've got this big experiment going on, and I think we're taking it to conclusion and I think it's going to save them what they need. I think they're going to balance their budget because they worked together. Which I think is shocking to a lot of people. But also, the Partnership has solidified itself. Vallejo, CA, as far as the clinic is concerned will never be the same because they know how to make it work. I mean they know how to partner. And so

that's one instance of one clinic being in a hell of a problem and reacting to it through the Partnership. They couldn't react to it any other way because they needed the cooperation of the workers.

Summary

The main points that have been developed can be summarized under broad categories.

Overall Engagement

The structures necessary for the Partnership to function are in place. Joint labor- management groups meet regularly for the overall service area as well as for the four clinic locations. These groups are co-chaired by union representatives.

The development of Partnership committees at the departmental level is underway. In Pediatrics and the Chart Room, these committees have successfully addressed major issues of staffing and planning for Health Connect.

The number of union representatives has been expanded substantially, and most have received training in interest-based problem solving, consensus decision-making, and union partnership representation.

Leadership

The Partnership has highlighted the importance of effective leadership. In this connection, the following are worth noting in the experience of the Napa/Solano service area:

- A number of managers have been replaced
- Managers are learning how to manage in a partnership environment.
- Union leadership has been fluid, with turnover of servicing representatives and restructuring of the chief steward roles. (The fact that most union locals contain members who work for other employers where relationships may be more traditional creates alignment issues for full-time labor representatives.)

- Physician involvement has been spearheaded by the PIC for the Laboratory. Napa/Solano is fortunate to have his leadership at the service unit level as well as his troubleshooting role at the departmental level.

Process

The Partnership brings people together in many meetings but these meetings are sometimes less than productive, suggesting the need for training in how to run an effective meeting. The Partnership can also create frustration and confusion when it is not clear how power and authority are being shared, as well as when meetings only address “management’s agenda.”

First, a budget crisis created considerable credibility for a program, with full disclosure of information, and the creation of a coalition for change.

Although it was necessary to combine and shift strategies: from a fostering emphasis (during this phase, the departments were urged to come forward with suggestions) to a forcing mode (when key leaders took the initiative, agreeing that vacancies remain unfilled and create a process for balancing the workforce on a daily basis.)

The Partnership places new demands on stewards and union representatives to attend meetings, to arrange for “backfill,” to report back to constituents, and to juggle time and role conflicts.

The Partnership affords departments an opportunity to expand their mission, e.g., the Supply Department, with its Cost Busters program.

The Partnership enhances understanding on the part of employees for the key challenges facing the organization.

As a result of interacting connecting with key managers, union leaders have become much more knowledgeable about where to go in order how to resolve problems

The availability of facilitation is essential for helping the parties, especially at the departmental level move forward and deal with the many issues involved in effective meeting management and follow through.

Facilitation played a key role, helping people at the departmental level, as well as at the central steering committee level, to implement the program.

To the extent that the Partnership evolves into a generic process that engages employees and uses the tools of problem solving and consensus decision-making, then opportunities may develop to involve nurses represented by CNA.

Crosscutting Themes

The development of attendance and tardiness guidelines has put the “thumb print” of union stewards on these important issues, with ramification for alignment within the leadership of Local 250.

The impact of Health Connect will be immense and the implementation issues are being addressed with care and concern by the manager of the Chart Room.

While the cost-reduction target of \$10 million has been achieved and sustained, it has been much more difficult to reorganize work to achieve a better balance of workload and available staff.

The cost-reduction program has given the Partnership at Napa/Solano “legs” and as a result of the social capital that has been developed in the process of successfully achieving the target, the parties are positioned to realize other joint gains.

APPENDIX

COST REDUCTION INITIATIVE

The showcase for the Partnership at Napa/Solano is the process underway to reduce costs on the clinic side by a substantial amount. Joint staffing has been a topic high on the priority list for the larger partnership between Kaiser Permanente and the Coalition of Unions. In this Napa/Solano case study, the unfolding of a joint staffing program can be seen in its full complexity.

Background

Because enrollment had been flat or declining, and the service area had budgeted for an increase in enrollment, the organization found itself running a substantial deficit, and pressure was mounting to correct the problem rather quickly. In the 2002, the clinics had exceeded their budget by \$10 million, and in 2003—at the pace realized early in the year—the deficit could amount to \$15 million. As of April 2003, the deficit had already increased by an additional \$3.5 million.

The rule of thumb followed by the planners was that a drop in 1,000 members meant a loss of one million dollars in income. Therefore, the projected decline in enrollment during 2003, of almost 5,000 members, meant that if nothing changed they would be exceeding their budget by an additional \$5 million.

Launching the Project

In assessing options for going forward, Sandy Rusch met with Tony Gately to discuss the challenge. Tony suggested that they include Wil Clayton, a representative from Local 250, in this conversation. As a result, the decision was made to launch a special project, and to view it as a stand-alone activity, benefiting from the labor-management Partnership but not integrated in with the governance of the Partnership at Napa/Solano.

A formal kick-off meeting occurred on April 11, with Gately and Clayton present, as well as chief shop stewards from all the facilities in Napa/Solano, and a comparable number of managers. The group numbered approximately 40 individuals. At this meeting, Dr. Stricker, the physician in charge, made a detailed presentation on the reasons for the financial crisis and in effect “opened the books.” Considerable discussion occurred, and in the lexicon of change management, the meeting served the purpose of “unfreezing” the status quo and motivated the parties to design a program to reduce costs.

The first task was to set the target for the program. An important step undertaken by management involved visiting other service areas, especially Diablo, which had much better staffing ratios. The purpose was to determine what would be a reasonable target for reducing costs—which meant shrinking the number of workers and/or employee hours.

Together, Dr. Stricker and Sandy Rusch determined that they needed to reduce costs by a minimum of \$5 million, which would be keeping the cost level the same in 2003 as it was in 2002, with a stretch target of \$10 million.

Dorothy Christiansen describes the launch of the cost-reduction program:

So Gately knows that he's the head doctor watcher and he knows how much trouble they're in. So he calls all the troops in. The union comes, Local 250 sends its division head [Clayton] up here. They send me up here. Everybody comes up here to hear Dr. Stricker [the PIC] talk about how much he needs their help to save \$10 million or so. The union and management and just the Permanente Medical Group, the docs, not the hospital, just the docs, the clinic. So they say "OK. What are we going do? We need people's ideas on how we save money." So that was cool.

To carry the project forward, a steering committee was formed consisting of key people from management, including Dr. Stricker and Dr. Nathan, a pathologist. Also included were medical group administrators and managers and stewards from the four facilities: 2 each from Napa, 2 from Vacaville, 2 from Fairfield, and 2 from Vallejo. In addition, the business agent for Local 250 joined the committee. Local 535, which represents social workers and staff psychologists, was not part of the cost reduction initiative.

Establishing Credibility

During the first meetings of the steering committee, a crucial step involved establishing credibility for the program. Historically, little financial information had been shared with union leadership. One of the first questions asked by the union representatives was whether employment numbers for those in administration were in line with other facilities. In answering this question, Sandy Rusch provided data that tracked the number of administrators over time, showing that the numbers had not changed; if anything, positions had been reduced. By contrast, the data showed that the number of people who were providing direct care had increased steadily.

It was important at this stage for the committee to hear from the physician in charge, Dr. Stricker. He presented a compelling story of the need to reduce costs. In addition to the factual data, he reminded everyone about the importance of maintaining employment security. Later he would recall:

Every single meeting I come to the group saying, "Look, everybody is keeping their job. Everybody is keeping his or her paycheck. Everybody is online for a raise. And that's my goal. I keep waiting for everybody here to send me a thank you note for protecting their job and their raise. And I haven't gotten one yet, OK?" And what I'm here for and why we're having all these meetings is so that we come as close to perfect agreement over where people are going to sit and what facilities they're going to work in so that these changes have the least effect on your lives as possible.

A key task for the steering committee was to identify priorities for the project. Clearly, reducing costs by a minimum of \$5 million would require reducing the size of the workforce since payroll accounted for virtually all the variable costs.

In discussing how to surface ideas, the steering committee decided to establish working groups at the department level, and to encourage them to meet and make recommendations about how to reduce salary costs. In total, 15 subcommittees were established, especially for clinics that were substantially over budget or where relationship problems existed, such as on OB/Gyn.

Dr. Stricker emphasized the importance of involving employees at the department level in a process of joint decision-making:

We have the opportunity to observe how different clinics function at lower staffing levels, and to encourage them to find ways to get the work done in these periods of downsizing, because ultimately we need to hammer out agreements with labor and management that result in down-staffed clinics.

In bringing the various committees up to speed, the parties engaged Restructuring Associates, Inc., and one of their consultants, Charlie Huggins. In his facilitation work, Dorothy Christiansen, retired commissioner from FMCS, joined him. Huggins helped develop the knowledge base needed by the committees for interest-based problem solving, as well as consensus decision-making. He urged the committees to tackle “low-hanging fruit,” and in his facilitation work, he focused on the departments where in his estimation fairly large savings were obtainable.

Reporting Back

By June 2003, the steering committee had received a large number of suggestions from the departmental groups. These suggestions fell into several categories. One involved closing clinics just before a holiday—what was called “near-holiday closing”. Another aimed at covering vacation and sick call absences with regular employees and not utilizing call-ins. A third theme involved voluntary reduction in hours, e.g., *“Rather than being a 40-hour person, I’m willing to be a 32-hour person.”*

As the stewards from Pediatrics explained the process: *“In our department we were able to come up with a better matching of the staff with the doctors’ schedules. Since not all doctors work Monday through Friday, we matched our staff days off to when the doctors were off, thereby helping the budget.”*

Dorothy Christiansen summarizes the content of the work:

They come back and they’ve got 35-40 suggestions. Everything from close on Halloween afternoon because little kids don’t get sick on Halloween night... Really innovative ideas, like “We should close OB-GYN on Friday in Fairfield because we hardly do any business on that day.” All kinds of things. Some good, some not good. Some would save \$45 and some would save \$5,000. So we went through those systematically. “This is pretty good. Do this.” And then we went back to

the field and said, "Ask people if anybody wants to reduce their work week." Sure enough, some said, "Yes, I'd like to go from 40 to 36 and I'd like to have every Friday afternoon off." Somebody else says, "I'd like to go from 32 to 28 and I'd like to have every other Friday off." So we found people who are literally willing to cut their workweek. That's got to be saving money IF you can cover for them without hiring replacements.

A Pivotal Event: Coming Up Short

In reviewing the suggestions coming from the various departments, Sandy Rusch estimated that approximately 40 FTEs could be saved when these ideas were implemented. However, by her calculations, to approach the target of \$10 million, 140 FTEs would have to be identified.

Also, it appeared that the process had started to bog down. Charlie Huggins, the facilitator, captures this point:

The steering committee put together a good process, defined objectives, and allowed people to become engaged. The mistake that was made was that the leadership team reserved for itself the role of reviewing all recommendations that came from departmental work groups and then giving final approval. They struggled mightily, wrestling with fairly insignificant changes that one person or another, often from the union side, thought would create havoc or could not possibly be in line with the requirements of the labor agreement.

So it became clear to the steering committee, especially members on the management side, that the "bottom up" process had to be put aside and attention turned to "how can we save big money fast?" This shift in focus represented an important "pivotal event" in the unfolding of the cost-reduction program.

Sandy Rusch and Dr. Stricker proposed several steps to hasten the process of reducing costs. First, no open positions would be filled, even on a temporary basis, meaning there would not be any job postings for permanent replacements. Second, something needed to be done about daily staffing. The thought was that if call-ins could be avoided, then considerable money would be saved. This had been a goal from the start, but no mechanism had been put in place to achieve this result. To this end management proposed that every morning at 6:00 a.m., Dr. Stricker, Sandy Rusch, and representatives from the union meet to balance the workforce for that day. This process in some cases could result in shifting workers from departments where no staff shortages existed to other departments where there might be a shortage.

After caucusing, the union leaders endorsed the plan. As a result, key union representatives participated daily in the work-balancing meeting at 6:00 a.m.

Outcomes

As of December 2003, substantial progress had been made in the cost reduction program. The program had more than met its target of FTE reductions, with the number saved reaching 145. The dollar savings had grown to \$10

million. This total consisted of approximately \$2.8 million on the physicians' side (primarily holding positions vacant that occurred during the year), and about \$7.2 million on the staff side. About two-thirds of the latter came from reducing the headcount—holding positions vacant, avoiding the use of on-call, etc. The other one-third involved shorter hours—either closing near holidays, workers volunteering shorter hours, and reduction of overtime.

When I returned to Napa/Solano in August 2004, management and union officials reported that the cost-reduction had been sustained. The 6:00 a.m. meeting for balancing the workforce was no longer needed, and the facilitators (Charlie Huggins and Dorothy Christiansen) had moved on to other assignments.

However, the expectation that additional savings might accrue from the work of the departmental committees has not been realized.

During my interviews in August 2004, I probed for ongoing challenges and issues associated with the cost reduction program.

- Many departments wanted to have openings filled, and Sandy Rusch was being urged to authorize hiring. In a few cases, this had happened. As Dr. Nathan explained the procedure, *“A subcommittee with the LMP and the cost reduction program has been established to discuss how attritions will be dealt with. If, for example, Vacaville says ‘We have lost 3 positions and they have not been replaced,’ then we in the committee will make a decision whether or not to replace any.”*
- A number of people indicated that stress had become a factor. The expected reorganization had not taken place, and as a result many employees felt stretched: *“In our department we are working with short staff. This has created some animosity and lots of frustration. Some weeks I cannot get to my voicemail for two days. People call me and my mailbox is full.”*

To quote Dr. Stricker:

We have not, in a formal way, as of yet, through our leadership group, ratified into stone the changes that have been made together with the union partners on a daily basis. We are meeting the financial targets, but we need to make these temporary changes permanent.

There also was some evidence that the use of on-calls may have been cut back too sharply. A chief steward made the point, as follows:

Some of the on-calls have been working close to full time, and now the on-calls are not getting any work. So suddenly the organization has lost these on-calls because they have gone to other organizations to work. And now they may need them and they are not available. I think from management's point of view, they felt they met the cost objective, and that's their ballgame. But I don't think they've thought about all the consequences.