

# **JOINT STAFFING PROJECT, SUNNYSIDE HOSPITAL**



I W E R

Institute for Work & Employment Research



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## I. Background on Project/Facility, Catalyst for Effort

Sunnyside Hospital is Kaiser Permanente's only hospital in the Northwest region. (Another KP hospital, Bess Kaiser, was closed in the mid to late 1990s in an episode that caused bitterness and undermined trust among the unions and the workforce which remains today.) Sunnyside has over 180 beds. Five unions represent workers at the hospital. Three are in the Coalition of Kaiser Permanente Unions (CKPU) and involved with the LMP: the Oregon Federation of Nurses and Health Professionals (OFNHP, AFT), Service Employees International Union (SEIU) Local 49, and UFCW. The Pharmacy Guild, a small independent union, and the Operating Engineers Local 701, representing the hospital engineering staff, are not involved in the LMP. (The Security Officers also recently organized into the ILWU via a non-NLRB election.)

Throughout the period covered by the case study the hospital has faced various challenges. The hospital has been growing physically and will continue to do so. At the same time, like other Kaiser facilities, it is under pressure to contain costs, "a huge challenge" according to now-former hospital CEO, Kathy Wegener. Midway through the joint staffing process, in 2003, there was a change in regional policy referred to as "Sunnyside First". This policy encouraged the use of KSMC as the hospital of first choice among KP members in the region and substantially increased patient census. The hospital is also engaged in continuous technological change, including but not limited to AMR/Health Connect. All of these changes must be implemented "without comprising quality or service."

The joint staffing project at Kaiser Sunnyside Medical Center (KSMC) began as a Pilot Project of the national joint staffing effort. The National Agreement on Joint Staffing emerged out of the national interest-based bargaining task force on quality and service. The agreement itself is brief. The underpinning of the agreement is the recognition that "the ability to provide quality health care and service to . . . patients and a quality work environment for . . . employees, is influenced by a number of variables, including how we staff." The agreement sets up a framework for the creation of joint staffing teams which were to recommend annual staffing plans designed to improve health care and service quality and employee satisfaction. These plans were to take into account a range of factors including things like patient needs and acuity and volume, standards of professional practice, and model of care. Plans were to identify "system and process problems that undermine quality healthcare and service and were to include the tracking of quality outcomes.

The Northwest region chose KSMC as their pilot site for a variety of reasons. It is the only hospital in the region. The director of nursing and the current president of OFNHP had been part of the national bargaining task force that had developed the joint staffing agreement. The unions and regional management were looking for an initiative to "kick start" the LMP in the hospital. Finally,

there was the obvious desire to work on the problems that the joint staffing process was intended to address.

As a pilot, the project received funding from the national level for facilitation from Restructuring Associates (RAI) as well as from an internal LMP consultant, Connie Van Metre. RAI facilitated the joint staffing committee process through the end of 2003, but was not involved in the implementation of staffing plans. Release time for participation in the various committees was funded locally.

It is important to note that throughout the period prior to the research, the partnership at Sunnyside was stagnated. This stagnation is documented in an assessment report authored by RAI in December 2003. RAI concluded that 1) “There is not a clear and shared view of the purpose of the partnership at KSMC”; 2) “There exists minimal shared understanding of the key principles, structures, processes and commitments essential for effective implementation”; and 3) There is a need to strengthen the unions’ partnership role at KSMC.

Shortly before the site visit was conducted, the LMP leadership in the Northwest had hired a full-time “labor partner” for the hospital CEO as part of the broader regional effort to partner all mid and upper level managers with a union representative and as another way to move the partnership at Sunnyside itself. More recently, that CEO was replaced with someone viewed as more labor and partnership friendly. As such, this study of the Joint Staffing project caught it at what may turn out to be a transitional moment. This point will be elaborated on below.

## II. Description of Process

### Overview

The Joint Staffing Project at Sunnyside began in 2001 with the establishment of the oversight committee. The original sponsors of the committee were Kathy Schmidt for the union coalition and Jim Pruitt for management; Steve Francy later replaced Kathy in that role. The KSMC Joint Staffing Committee was also supported by and reported to the KSMC Partnership Steering Committee. This oversight committee was originally chaired by Sherry Socotch, Assistant Hospital Administrator, Nursing, and Keith Glasser from OFNHP. Later, Glasser was replaced by Anne Fraver, a respiratory therapist. Members of the Joint Staffing Committee included three representatives from OFNHP, three representatives from SEIU and two from UFCW, and seven managers.

The oversight committee began meeting in January 2002. The committee was trained in meeting management, goals and measures, budgeting terms and process, marketing and rate setting, the regional financial situation and the developing of staffing plans. According to one of the consultants supporting the

project, the “original vision was the oversight committee would look at metrics and systems issues.”

The purpose of the departmental/unit level Joint Staffing groups, according to guidelines drawn up for them, was 1) “To jointly develop a mutually agreeable staffing plan within allocated resources, plus a plan for periodic evaluation and adjustment” and 2) to identify budgetary issues for prioritization and consideration by KSMC Joint Staffing Committee and KSMC Budgetary Committee.” As Jim Pruitt, the regional Labor Relations Director and management sponsor of the project, put it, “The goal of the project was to see that each unit in project was “appropriately staffed to meet everyone’s interests, especially patients, then employees, lastly the institution.” At the same time, Kathy Schmidt, the original labor sponsor, argues that the unions expected that the major focus of joint staffing would be the systemic issues, “the factors that drives us insane in trying to get the work done. [Things like] looking for a chair, a clean commode. A pill not delivered. That got articulated at the kick off.” Finally, as mentioned above, the partners hoped that the staffing work would help to advance the LMP at KSMC.

One of the early tasks of the oversight committee was the selection of the units for the initial Pilot Projects. The criteria for these first projects were units that were highly visible, with diverse work groups, where there were immediate needs for staffing changes and where it was possible to achieve “easy wins”. It is not clear how this last criteria was applied given that the first unit to engage in the joint staffing process was “1 South”, widely described as problematic by both labor and management representatives. Indeed, this was reflected in a very difficult experience for this unit, described below.

The oversight committee also developed a standardized process through which unit committees would operate. Elements of the process included training (IBPS, Consensus Decision-Making, Root Maps, Budgeting, Patient Care Models), gathering data, meeting with constituents, identification of key issues, all of which were to culminate in the development of a joint staffing plan using IBPS. Plans were to be submitted to the oversight committee “for review and recommendation”. As suggested by the guidelines cited above, any requests for additional resources (staff) would have to be carefully justified and required approval from the oversight committee. The pressure on committees to develop plans within existing budgets created an early substantial constraint on the plans and created some resentment among union representatives: “If [a Joint Staffing committee] saw the need for more [staff and budget], started talking about more, the discussion would get really tough.” On the other hand, a consultant involved in the project argued that “the data didn’t support extra staff when compared to benchmark data. . . Frankly, in most cases they had plenty of staff, but they were unwilling to look at their work design and change how meals, breaks, training, etc. was managed.”

At the beginning, there was an emphasis on measuring the impact of the joint staffing plans. The oversight committee reviewed measures already being used in the medical center and instructed departments “to identify 4-6 measures of their performance.” Each measure was to be “collected and charted for a 12-month period prior to the formation of the department joint staffing team/group and then monitored regularly by the committee/group.” As discussed below, this has been implemented unevenly at best. As the projects progressed, the oversight committee “lost traction and lost members.” The committee leadership became distracted and were not replaced; many members stopped attending the meetings that were held.

On November 17, 2003, the LMP hosted a day of learning and celebration during which teams met and discussed the process and outcomes first among themselves and then reported to the full group. As part of preparing for this day, teams were asked to present their outcome measures. This provided an impetus for most groups to circle back and look at their metrics. The descriptions of the unit staffing efforts below are based on the public presentation at the learning/celebration day, interviews with committee members and other labor and management representatives and committee documents including the plans themselves.

## Units

### 1 South (20 bed stepdown unit)

Process. 1 South was selected as the first unit to work on joint staffing. The original committee first met in July 2002. For a variety of reasons, it is not clear that the unit was the best choice to go first. For one, relationships on the floor were not good at the start: “[This was a] problem floor, a problem group.” The nursing staff is divided into two teams, as they are on other patient care floors, and relations between the two teams are competitive. At least one manager argued that the relationship problems were more between staff and union activists and leaders, while union leaders reported bad relationships between RNs and CNAs. In addition the work of the unit is difficult: “The biggest issue in my mind with 1 South is patient acuity. 15 years ago, most of the patients on the unit probably would have been in ICU. In today’s climate of trying to keep cost down, they end up in a stepdown unit much sooner than in the past. The work is stressful, families are on edge, etc.” An OFNHP leader claims that union and management cannot even agree on the correct term to describe patient acuity on the floor (stepdown vs. progressive care). In short, 1S was a prominent battleground for labor-management struggles in the hospital.

There was also a problem in the initial selection of the joint staffing committee members. The original members were closely identified with the Unit Based Council (UBC). Unit Based Councils exist in all the patient care units and are a structure born of a nursing practice model (Clinical Practice Model) that

predates but has some overlap conceptually with the LMP. UBCs include various unit stakeholders and use, among other tools, consensus decision-making. However, UBCs were also “heavy on Charge Nurses” and were thus not representative of the nursing staff as whole. In fact, the original nurse representatives to the Joint Staffing committee were all Charge Nurses. It became clear at some point that the joint staffing committee on 1 South was not “the right group”: “Charge Nurses were trying to represent regular nurses.” Additional members representing other constituencies, including CNAs, were added later as well as additional representatives to make sure all shifts and both teams were included.<sup>1</sup> While this broadened the representativeness of the committee, it also caused problems in that new people were constantly joining and were not trained with the original members, which weakened their already strained ability to work together.

In addition, one labor representative reported that when CNAs did begin coming to the meetings they were intimidated and had difficulty contributing. Over the course of the process, this changed: “Now, the CNAs are speaking up. The change is huge.” A manager confirmed: “I believe most people on 1 South would say things have improved.”

An additional problem, also experienced in the other units, was the communication and relationship between the committee and its constituencies. Although the committee felt that they had tried to keep in contact with their peers, talking to co-workers on their shifts for instance, non-committee members still did not feel included, especially if they disagreed with decisions made by the committee. A manager put it this way: “This communication did happen following each meeting. However, any staff whose idea was not the one selected was very vocal in stating that there was not a partnership and she was not adequately represented.”

It is interesting to note that the committee identified numerous “system issues” to be handed off to the KSMC Joint Staffing Committee. These included issues related to food and snacks, supplies, equipment (organizing of, training for, management of), and paperwork. They also included issues around physicians including time wasted figuring out which physician to call and how to clarify physician’s expectations.<sup>2</sup>

Plan. Despite these glitches, the committee did arrive at a plan and the plan was implemented, at least by half of the unit. One labor representative characterized the plan as a result of a compromise that enabled a plan to emerge without developing any real agreement on staffing levels. The formal plan included the following changes:

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<sup>1</sup> Union and management representatives still disagree on what happened in the initial selection of committee members, each blaming the other.

<sup>2</sup> It also identified a second list of system issues to be addressed by the “Unit Partnership Committee”. There are some overlap in these two lists. Other issues sound like staffing issues, like CNA continuity, and coverage of break time.

Changes in CN jobs: Reduction in CN patient load. One of the nursing teams “embraced” this change while the other did not, at least at first.

Changes in the way CNAs were assigned. CNAs were originally assigned to a part of a hallway; they are now assigned to RNs. This is “working better” though there are still some problems

The addition of a 4 hour secretary (working 9-1) to cover orders and transfers. At least one committee member reported this was helpful but the position was needed for 8 hours. This was intended to help with the churn factor described below. They’ve asked to extend this position.

Added a CNA unless census drops below 13.

Staggering nurse lunches – Mixed reports on how well this worked.

Moved the reporting time for some staff 15 minutes earlier and before the rest of the hospital.

Changed the handling of shift changes – Reduced report from 45 to 10 minutes.

Outcomes. The committee chose outcome metrics in four areas: budget, patient flows (ADT), quality of care, and retention/attendance. These outcomes were assessed in Fall 2003, a little short of a year after implementation.

Unit Budget Variance: The unit has a negative budget variance, driven by high turnover, open positions and related high agency costs.

ADTs (Admits, Discharges and Transfers): This turned out to be less an outcome that was under control of the staffing process and more an input into the staffing plan: “There was a perception that there was a huge increase in the workload during certain hours of the day, due primarily to the churn factor which in on our unit is pretty intense because just by the nature of the unit. We get them in from ICU, we get them well enough to go to a floor, they go out. . . There’s [also] a lot of movement within the unit.” This led to the addition of a CNA (see below).

Quality of Care Measures: Patient Falls, Medication Errors, Narcotic Discrepancies, Chart Audits: Improvements in all of these though difficult to be sure it’s a result of new staffing. For instance, there was a 33% decrease in patient falls in the months before and after the implementation, but the numbers are small to start with. “It’s difficult. The numbers are very small if you look at them. It’s a snapshot of a period of time. So, I’d like to think that improving the staffing and improving the patient care ratios would improve quality of care, but I believe it’s going to take us a little more time to evaluate that. So we’re ... doing

the chart audits, we're doing the dual track Narcotic Discrepancies. We can monitor our own med errors but we're more concerned with Narcotic Discrepancies. And patient falls."

**Retention/Turnover:** Turnover remains too high though the new "no cancel" policy will help attract new employees. This unit has a reputation of having a heavy workload, so as one manager reports, the staffing changes in the unit have helped with that reputation and improved recruitment.

**Sick Leave Usage:** Depending on who is reporting, this has stayed the same or gone up.

**Worker's Comp** – injuries were down although it's not clear if that will hold.

Unlike several other units, People Pulse scores were not chosen as an outcome metric by 1 South. We reviewed them in any case. Pulse results are mixed with some measures showing improvements and others declines. The scores for the question "There are enough people in my department to do the job well" (hereafter referred to as "the staffing question") actually declined in this unit, perhaps reflecting the continuing turnover/open positions problem, the uneven implementation of the plan and/or the particular timing of the survey. Despite all the problems and the mixed results, however, informants from this unit felt that life on the unit had improved. At the same time, with the new hospital leadership in place, the parties are revisiting the staffing on this floor.

### Emergency Department

**Process:** The Emergency Department (ED) was also early in the process. The department had a large committee with as many as 18 members at one time, reflecting a lack of trust within the department. In fact, at least one informant reported that the committee was too large. Despite the size and the good mix of people on the team, the participation of the one CNA on the committee was uneven due to scheduling problems.

The ED was another unit with a history of relationship problems. A management informant from outside the unit argued, "The ER has always been a place with many independent players and non-functional relationships. So they had to do a lot of relationship building. They started out very mistrustful but in the end became very cohesive. They were able to reach a consensus around the use of the budget and the need for additional staff." A member of the committee put it this way, "It was very difficult at the first few meetings because we were running into a lot of obstruction with people's attitudes both from upper level management and mid-level and the regular staff level."

While some committee members reported that there was good teamwork on the committee, it is less clear whether the improved relationships mentioned above are really evident in the unit. In particular, there was, both on the committee and

within the department, continued fundamental disagreement around the role of the Charge Nurse (see more below). A unit manager reports: "I can't say it hasn't had any impact. But the impact is not necessarily positive or negative. There is an impact there. There is still animosity and mistrust that I don't quite frankly know if we'll ever get over it. . . . But we have come a long way and it's a step in the right direction."

Unlike most of the other patient care units, the ED did have the participation of a physician, in this case, the Director of the ER. A unit manager saw this as a very positive thing: "He participated in every meeting... he knew what the expectations were. He knew what we were going to try to accomplish . . . and he knew what he needed to do to help that happen. He's very good . . . If he has concerns from the docs about the nurses, he relays those. If we have concerns, he takes those back. So he acts as a kind of liaison between those two groups which is very good. . . . He had some issues that he brought up." A union informant seemed less sure: "He didn't attend all the meetings. . . . He had a specific desire and his interest was specific: 'We want a 24 hour dedicated Charge Nurse'." In fact, he argued, the physicians in the department generated that idea in the first place: "As far as I understand it, they were the ones who generated the desire for having a dedicated charge nurse. They were the ones who were really rolling the ball basically as far as trying to get this situation changed." At the same time, everyone agreed that it was better to have the physicians as part of the staffing process.

The Charge Nurse issue is a hot-button one here as elsewhere. From management: "There are people in the department ... who do not believe in the dedicated CN role, who think it's ridiculous. And there are professional saboteurs. . . . When I ask them why, what is the point in this? . . . 'things have always been done this way and they work better.' Well, define better. . . . I think they perceive at times that the CN does nothing. What they're not seeing is that the CN is controlling the whole flow of the department, answering phones, they're sometimes transporting patients, if there's a real sick patient and a weaker nurse, they're in there mentoring and assisting, so they're not seeing the big picture."

A nurse expressed a different view: "Some of the people at the mid-level area have a different idea of what a Charge Nurse was. I don't know that we've ever really resolved that. We still, in the ER department. . . ., we still have a problem with a vague representation of duties and how the role is performed by each individual Charge Nurse. . . . I think [the unit manager's] opinion of what a Charge Nurse is doesn't coincide very well with mine and some of the other Charge Nurses. I think that has been a main issue as far as progression through this whole thing. I have great respect for her but I disagree with her. . . . Basically, she felt that a Charge Nurse role was that the Charge Nurse had no hands on contact with patients. They kind of stepped to the middle and directed. In actual practice in my view, yes, that's what the Charge Nurse should do, but they do need to get their hands on, they need to get involved." "One of [the manager's] points was that 24 hours a day we would have our dedicated charge nurse,

meaning a charge nurse that took no patients. That was a constant argument, and though we agreed in principle that yes, that would be ideal if that could happen, sometimes during the day it's not possible. The load is just too heavy for everybody else. The CN does have to take patients sometimes." The argument over the CN role is an extension of past bargaining fights with management pushing first to establish the title and then to define the role. The difference in views of what the CN role is actually varies among the nursing workforce and union activists and across units, is strongly nuanced and is discussed further below.

As with the other groups the ED committee struggled with communicating with their co-workers. Although they posted their minutes and committee members tried to communicate with their constituencies, there were still many complaints that information about the process and plan did not make it back to the staff, which in turn reduced their buy-in.

Plan: The staffing plan was relatively simple. As a unit manager put it "One of the things that came out from the staffing project was that the staff felt they could not possibly deal with staying off divert and keeping patients happy because they were so overworked. And that was their bottom line. Through looking at the staffing matrix and through looking at the acuities, the number of patients we saw per day, the number of ambulances we saw per day and looking at the budget. . . it was determined that, you know, we probably are somewhat short-staffed. And so we added some positions."

--Charge Nurse stop taking patients unless patient volume too great.  
Added an RN to backfill for CN from noon to 12:30 am.

--Added a Unit Specialist at night to help CPCA

-- Added a CNA Monday through Friday day shift in order to move nurses off non-nursing functions like stocking to help enable dedicated CN during this time.

Outcomes:

Diverts

# of diverts per day

Length of time on divert status

There was a dramatic reduction in the time on divert and number of diverts. In the seven months after the staffing plan was implemented, the *time on divert* for most months was  $\frac{1}{4}$  that of the previous year. It is interesting to note that reductions in this metric actually began prior to the implementation of the staffing plan, although those reductions were not nearly as dramatic. Similarly, the *number of diverts* for those same months averaged about a third of

those from the comparable months in the previous year. Despite their importance, the unit manager reports that these reductions are not easily translated into numbers: “There was a dollar amount of \$38,000 and I’m not sure where that came from, because we can’t really break it down.”<sup>3</sup>

Patient satisfaction – didn’t have yet

Variance to budget – they went over budget

Attendance/# of unscheduled absences per staff member – Total unscheduled absences were down somewhat overall with small percentage decreases in sick time and emergency absence without pay.

Length of stay of patients – The average length of stay stayed about the same for January through April of 2003 as it had been in those months in 2002. However, the length of stay dropped significantly from the previous year for May through August.

“Hot times” (# of patients during period when most staff is working) – N/A

Customer complaints per month – Customer complaints in the three of four of the most frequent complaint types were also reduced, in some cases by as much as 50%. These types are employee communication and attitudes, quality of care and quality of service. Qualitatively: “I think we’ve had less complaints from patients – “well, I sat there for hours and nobody did anything for me. . . I’ve noticed more on the board we’ve been getting more positive comments from patients, cards: “Thanks for everything we did’.”

# of patients left without being seen per month – The number of patients leaving without being seen or leaving against medical advice dropped in most months of 2003 as compared to 2002, in some months substantially.

Staff satisfaction – The changes in People Pulse questions were more consistently negative in the ED than in Sunnyside overall and than the other units involved in Joint Staffing. At the same time, those negative changes were mostly small. For instance, on the key “staffing” question “There are enough people in my department to do well”, there was a 3% decrease in those answering positively from 2002 to 2003.

## 1 NW Oncology

1 NW/Oncology is a 15-bed unit caring for KP oncology patients.

Process: One union informant with experience across several committees called this “the best group I worked with”. Perhaps learning from the experience of the

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<sup>3</sup> The May 15, 2003 Partnership Progress Notes reductions in diverts by 64% with a savings of \$38,000 for a single quarter.

committees who started earlier, every “role” was represented on the committee. Labor and management representatives agreed that there was equal participation by different occupational groups and that all voices on the committee were heard. Relationships within the committee were solid at the start: “My group is really pretty cohesive so we didn’t have to start out smoothing over any relationship particularly.” One observer relates this to the special patient population that this group serves: “They’re dealing with death on a regular basis, so they don’t sweat the small stuff.”

Despite harmonious internal relations and good process, this group still had trouble with their co-workers who weren’t on the committee: The efforts to involve their constituents included conducting a survey, but it was not enough: “People would like to see more actual surveys so that they could participate more actively as individuals. They thought also the communication back could be a little more thorough, even though we thought we were communicating the heck out of it. I don’t know what else we’d do.” One non-committee member, for instance, reported, “[I] heard too many different story versions and when questioned people either became flustered and unsure or aggressive and confrontational.”<sup>4</sup> Another said, “Two people were consistent in asking me [for input. But I was] not too aware of how the committee as a whole was hearing concerns.” As a unit nurse manager put it, ‘it was hard to hear negatives from co-workers. . . .As I reminded people, just because we didn’t decide what you wanted to have happen, doesn’t mean we didn’t talk about your issues.”

There was no physician involvement in the process although they have been impacted by some of the smaller changes like the better protection of breaks: “We didn’t need physician input. I mean, the only input, the only involvement they’ve had is that when they come in the break room at lunch they say ‘Oh, does this mean me? I can’t come in and interrupt? My answer is ‘Yeah, actually, it does mean you. In fact, it especially means you’ . . . It would have taken a lot of time. Because they wouldn’t have known much about any of these things either. It might have been good in the long run to have a physician who is familiar with all this stuff, but I don’t know that they would have had a lot of input that would have really made sense and I’m not sure it would have been worth their time.”

Finally it is worth noting that this unit got negative feedback via a survey (see more below) on some of the changes, for example the new reporting system, that were part of the plan and made revisions based on that feedback.

**Plan:** As a union informant put it, this group produced the plan with “the most scheduling changes”. According to a manager on the unit, however, some aspects of the plan have not been implemented. Elements of the original plan included:

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<sup>4</sup> Source: Internal post-implementation survey conducted in Fall 2003 with all units involved in joint staffing process

- CNs – Had hoped to free up the Charge Nurse more to do more CN activities but that didn't happen – there weren't enough additional people to make that happen.
- Changes in lunches and breaks to help assure that everyone gets breaks and creation of overlap between shifts for RNs
  - 12 hour shifts for Unit Specialists (secretary)
  - Changes in reporting system
  - Changes in CNA handoff
  - Change CPCA to CNA
  - Second CNA at 11 patients rather than 13
  - Oncology Education - Two Oncology Workshops for everyone each year, planned to add computer for access to on-line education on oncology but not yet implemented.

The plan also includes detailed workplans for CNAs. The new reporting system didn't work and so this was revamped in fall of 2003 and had been implemented just prior to the site visit.

Outcomes:

Unit Budget/Overtime – Overtime had just begun to drop. Hours per patient day has also started to head down.

Staff Satisfaction with breaks and lunches, schedules, reporting/handoff, matrix, teamwork. The unit reports that it did its own evaluation survey focused on both the process and changes to which there were 10 responses. Results were mixed. Many of the changes were rated positively by all respondents such as the 12 hour Unit Specialists, the second CNA, and an additional RN at 12 patients. Those that were either not implemented (changes in CN role) or were viewed as negative (new RN schedules)

The People Pulse also has questions about teamwork. Two teamwork questions have been included in Table X; both dropped sharply for this unit from the past year. At the same time there were equally sharp increases in the degree of felt influence and in knowledge of and participation in the LMP. On the key question "There are enough people in my department", there was a 1% increase. Most respondents felt that their voices were heard by the committee and that were adequately informed along the way.

Patient Satisfaction with staff attentiveness and courtesy, noise, call light response, food and food quality – N/A

Patient Falls – Patient falls did drop between the 2<sup>nd</sup> and 3<sup>rd</sup> Quarters (the quarters before and after implementation) from 8 to 3. It's likely that this is as much due to the purchase of Ambulatory Alarms that go off when patients try to

get out of bed rather than the new staffing plan although the plan was expected to allow more sitters to stay with agitated patients.

Attendance/Ill calls – no decrease yet but new nursing schedules have only really just begun.

## 1 North

One-North is a 19 bed cardiac and medical/surgical unit.

Process: One-North clearly learned from the 1 South experience in putting together a committee: “We were shocked at the way 1 South set up their committee.” This committee from the start included representatives from the two teams and 3 shifts and included the various occupational groups (CN, RNs, CNA, Unit Specialist), but no physician. Reports from management and from the public celebration day are that the process went smoothly. Facilitation played a major role in that. The lower skilled members of the committee (CNA and Unit Specialist) needed some encouragement to become involved which they eventually did: “It takes a while for them to realize they’re just as important.”

Plan: This plan included some changes that were similar to other patient care units and some that were different. The plan was largely implemented though some things weren’t done at first and there has been “tweaking” along the way. Elements included:

- Freeing Charge Nurse from patient care. As elsewhere there was resistance, though in this case, primarily from CNs themselves
- Changes in the collaboration of RNs and CNAs – these include more regular discussion of patient care plans and ongoing patient care each shift and a flagging system to notify each other of changes in a patient’s status.
- Increased back-up support for Unit Specialist when things get busy
- Addition of either an RN or CNA on nights if patient census high enough to warrant it.
- Several changes in “behavioral norms” including things like coming to work on time, showing appreciation for each other, being positive, and picking up after yourself.

Outcomes: The outcome measures chosen by the team were

- Hours Per Patient Day – these have gone up
- Overtime – has gone up
- Attendance, especially unscheduled – There has been more use of vacation, family and medical leave and ill-time rather than less.
- Patients turned away – can’t measure

Patient injuries –  
Patient Satisfaction – No change  
Staff Satisfaction/People Pulse – As with the other patient care units, Pulse scores are mixed with some showing a negative trend and some positive. However, this unit had a 27 point increase in positive responses to the core staffing question, by far the highest of the units who have completed staffing projects. There is a similar (23 point) increase in the number providing a positive answer to the “recommend KP as a good place to work” question. This result may confirm a manager’s view that the “mood” on the unit has improved: “evening shift would come out of report angry, always understaffed. Now much better”.

### Dietary – 3 South Redesign

Process: This was a limited project, focused on the opening of the new patient care unit on 3 South and the integration of meal delivery with the patient care operations on that floor. The current “Kaiser Model” involves delivery of in-patient meals by an off-site commissary to assemble the meals almost to completion, refrigerate and deliver to patient care units where they are reheated and delivered to patients by CNAs. On 3 South, a new model was developed where a different technology is used to reheat the meals and they are delivered to patients by Dietary Aides. As a Dietician involved in the project put it: “We believed on 3 South that there may be enhancements that the Diet Aides could provide that would impact the quality of care for patients that we see. And the forms of things like I&Os [Intake and Outputs] and calorie counts being done more accurately. Enhanced customer service, in that the Dieticians would not be involved as much in food preferences, and just patient problems that involve food . . . . By getting that 3 South project to have Diet Aides up on the Unit would really enhance outcomes for our patients in that they’d probably be eating better and we would be getting better data.” The theory is that placing Diet Aides on the floor will allow them develop a relationship with and concern for the patient: “When they’re up there, they see it, you know. I think they’re very reactive to that human factor.” The joint staffing process developed the staffing plan to go with this new model is expected to be diffused to other floors.

The committee included three managers from different levels, a clinical dietician (OFNHP), 3 Dietary Aids (SEIU 49) and the Labor Liaison but no nursing staff. The process is reported to have gone well. As with most other committees, the major challenge was communication with constituencies. “The huge challenge, as with every group that reported out, was thinking that we were communicating enough and yet the constituents not feeling that. And getting past, ‘If I’m not at the table, I’m not represented.’” There was a follow-up review with all of the staff about 6 months after implementation that resulted in some changes to the plan. There was no physician involvement: “They really are irrelevant at this point in the process, our area of impact is below where the physician is.”

**Plan:** The plan involves a detailed task analysis, initial design of the positions and tasks each position will perform, and work schedules. The plan also involved some changes to current practice in the responsibilities of other members of the dietary department including some changes in tasks for certain positions and changes in record keeping and information flow.

**Outcomes:** No measures were defined by this group in the original plan. A number of outcomes have been examined in any case. (These tie fairly closely to the “customer requirements” described in the plan including things like “happy patients” and “good food”. These include:

-Patient Satisfaction – Based on surveys conducted in Fall 2003, 3 South has a much higher percentage of patients rating overall food service as excellent or good (90%) versus Sunnyside as a whole (65%).

-Nursing Satisfaction – 3 South, 2003 (100%) vs. Sunnyside, 2001 (41%). (The pre and post tools used for this were not the same, but the questions were similar enough to be comparable. (“There was a different tool developed by the labor co-chair of the committee who sort of passed it out to nurses at the last minute when we found out we had to have something to report.”)

--Employee Satisfaction – The People Pulse data for this small workgroup is mixed in with other food service employees in region so it is not useful and there is no baseline. [check back to see if they have done their own survey in 1<sup>st</sup> Q as planned]

The group did not choose to use patient outcomes as a metric for staffing: “Nutrition care outcomes would be interesting, but we’d need some help to do that. . . This unit has become such a ground for difficult patients, I think that until we get a better base, maybe the other units we could compare to each other.”

### Dialysis (In-Patient)

**Process:** Dialysis is a very small unit. The equipment and procedural and technical support are provided by an outside contractor (Fresenius Medical Services) which is also KP’s vendor for outpatient dialysis. The staffing and management are from KP: there is typically one RN and one technician on duty and only 5 regular staff members in the department aided by even fewer on-call staff. In management’s view, the Dialysis unit was tremendously inefficient and costly and way above community standards in terms of the staff to patient ratios. Labor disputed this from the beginning: “The unit that they were using [as a comparison], the Eugene unit [a similar size, but non-Kaiser, Oregon hospital], where they were saying that nurses were doing 1 and 2 runs by themselves, it was totally untrue. Because they had a Charge Nurse on, in addition to the nurse who was doing the treatments. So, they still did have 2 people in the department. . . I have done mobile at the other community hospitals, and when you were doing

one run, you're in a patient care unit, right there on the floor where you've got nurses and stuff right outside the door." Fresinius was unhappy with the high costs. OFNHP's position was that patient safety rather than cost should be the issue. Manager: "The [union's] agenda was to keep every job and keep every hour these folks had benefited from. . . Their belief was that management had the agenda of ultimately turning the whole operation over to Fresinius and bringing nonunion people in. Their perception was that this was the beginning of them turning the group over into Fresinius." Given this context, it not surprising that the process did not go well: "this went badly awry... Basically succeeded in pissing everybody off."

The joint staffing team consisted of the nurse, the technician, KP managers and a representative from Fresenius who has since become the KP manager of the unit. According to one participant, "The meetings turned into a classic oratory partisan battle. The dialysis staff accused management of not conducting the meetings in good faith. [They] accus[ed] administration of trying to get rid of the technicians and promoting unsafe care to save a few dollars." Even so, a plan did emerge, parts of which have been implemented. However, there have been no follow-up meetings and it's not clear that there will be any given how alienated at least one labor representative has become: "I don't think we'll get [the tech] to come back. She's not happy at all. She's the tech. I don't think she'll ... She just felt that more strongly than anybody that they were just trying to pick on us and browbeat us, administration, and it was kind of like the partnership for them was like an excuse, an opportunity." (There has been no physician involvement.) It might also be noted that this team did not get LMP training including Root Learning Maps, Consensus-Decision Making and IBPS; this may have contributed to their difficulties.

Plan:

- RN will run one patient if the patient is stable; RN decides
- Sitters for cognitive, behavioral problems: This has not been implemented.
- Breaks and lunch – resolved though not necessarily in the way the plan describes
- Sick Replacement – Used to have to find subs themselves; now working with Staffing Office – this is a good change.
- Replacing Open Shifts – Work with 3 South to do that

Although it is not really part of the original joint staffing plan, because they were originally located elsewhere in the hospital, the unit is working hard to better integrate with 3 South where it is located. 3 South has hired Dialysis trained nurses. "So now, I can run out the door and say 'Come in here for a minute.' Which is a total great change for us."

Outcomes: There is a significant complicating factor in looking at outcomes which is that the Dialysis unit began a new service (Slow Low Efficiency Dialysis

– SLED) which involves setting up runs in the intensive care unit. The measures chosen were:

-“Double back” – number of times staff are at work past midnight and have to return in am. Although the pay periods sampled showed no double back either before or after, the sense is that with the integration with 3 South, there are now nurses available who can pick up shifts or runs when needed reducing the need for double backs.

-Hours on call versus called in – The data for this were not gathered because it was realized in retrospect that the project could not change this since someone must be on call 24/7.

-Patients per day – There seems to be no change in volume.

-Patients cancelled per day

-Number of delays leading to overtime – it appears that more runs are being scheduled after 1 pm now than before the staffing plan was implemented. At the same time, the 3 South RNs may be providing enough back up to reduce overtime.

-Cost per run – has not changed, Fresinius still not happy.

-Staff satisfaction. In November, one labor and one management representative produced a report that concluded the following: “The 11 months of meetings and incremental changes that were accomplished did nothing to increase staff satisfaction, or satisfaction of their direct supervisor. The new no cancellation policy in October furthered the notion that nothing of substance was accomplished by the project and relationships deteriorated as a result of changing the core staffing. This caused one technician to use all of her accrued vacation to sustain her income in the period of March 1 through September 30, 2003. The organizational goal of lowering the cost per treatment was not realized. We did not calculate the cost of the meetings themselves, but are afraid that this would result in a negative dollar impact on the department because of the length of the process. The October 1 policy change now allows the tech income security at the expense of other departments when dialysis census is at zero to one treatment.” This bleak assessment is reflected in many, though not all of the Pulse scores: There is a 29 point increase in the report of too few hours reflecting the decreased hours of technicians. Most of the questions about influence show sizeable downward trend. At the same time, there was 26 point increase in the “recommend KP as a good place to work.” Perhaps this positive development reflects the sense of at least some of the nursing staff that the integration with 3 South represents a big improvement and that the department and particularly the manager is continuing to work on its staffing problems even if the joint committee no longer meets: as one staff member put it, “Slowly but surely I think that we are getting all these issues addressed.” In some respects, the very realistic, albeit bleak, assessment of the project by the unit manager may better enable this unit to move forward in the future.

### Dining Services (Café and catering)

Process: This was an early project among the various joint staffing projects at Sunnyside. The project began with a 5-person committee. "We spent the first meeting or so reviewing what individual participant goals or what we felt the issues were. Then we returned to those, then we honed in on a few of those and we focused on that more so than revisiting the partnership goals." The plan was not fully developed and implemented. A management informant indicated that just as the implementation plan was finalized, 2 of the 3 labor representatives went out on medical leave causing the committee to lose momentum: "To implement some of those other [ideas], we needed more of a presentation. Even putting new labor folks on could have worked, in theory could have worked, but it was a little tricky because they didn't have the detailed history." A labor representative suggested that the failure to implement was in large part related to resistance from the unit's supervisor who recently left. As of the time of the interviews, there was no replacement, which had left the staffing effort "in a holding pattern". It is interesting to note that there was a plan to use the LMP to develop criteria for hiring the new supervisor and to involve workers in the hiring process. This plan was part of the growing emphasis put on the LMP in the hospital in late 2003.

This committee experienced the same difficulties in its relations with its constituents: "That was just an ongoing, overriding issue with whatever we took forward. There wasn't a feeling of inclusion at all times. I think they did try to do their best to represent the issues but that was really difficult in a group, this group has been a challenging group. It had a history of not strong relationships in the department. There have been factions. And so faction A didn't get along with faction B and faction A folks were on the committee. . . We started that with our foundation." Despite these difficulties, some changes have been implemented and according to a management representative, the joint staffing process has helped the department work on other "festering issues".

**Plan:**

The plan called for a number of changes but it was reported that the following were actually implemented:

- Changes in scheduling to assure that breaks/lunches can be taken.
- Added a 16-hour/week position for peak times (for refilling/restocking):  
"Can we generate the additional revenue to fund that? . . . Our revenue has gone up in 2003 as opposed to 2002, probably for a multitude of reasons."

Outcomes: This unit is expected to actually generate revenue but historically has not done so. So the primary outcome measures are financial. Although the measures have been listed below, several have not been collected as of yet, again due in part to the lack of a unit supervisor. The loss of momentum and holding pattern discussed above includes a failure to look back at the measures identified for evaluating outcomes:

- Revenue/FTEs: hasn't been shared with staff
- Profit and Loss: There has been recovery of costs as high as 98% but they're at about 90% for this year.
- Revenue in café –
- Catering \$ per month – N/A
- Customer Satisfaction – Surveyed twice a year. No change from 2002 to 2003 but numbers are fairly high to start with.
- # of Customers served per day – N/A
- Non-productive time – Not tracked
- Unplanned absences – N/A
- # of unfilled/open positions – N/A
- Staff Satisfaction – The original intent was to do their own survey: “The trick is that we have to have enough of an engaged staff to want to complete those without strong-arming them – and we don't want to do that – so that's been a challenge for us, to start building trust and then we do the survey. It's hard to get the data right now.” The People Pulse is not an effective measure because this unit is intermingled with Dietary. Nonetheless, the mixed numbers do appear in the table. The mixed numbers include many large, downward trends including the core staffing question, for which there was an *35 point* decrease.

Environmental Services (No one from EVS was interviewed.)

Process: The committee reported publicly during the celebration event, that committee and member selection and training went well, that everyone had input – input was solicited from everyone in the department and worked into the committee meetings. However, union leaders reported that the joint staffing plan had, for the most part, not been implemented. Indeed, the manager of the unit became such a problem in the eyes of the workforce and union leadership that a multi-union job action was held and the manager subsequently went out on a Leave Of Absence and then left the organization. As with the other units, this committee reported some difficulty in dealing with negative constituents.

Plan:

- Movement of responsibility for particular areas from one position to another in an effort to balance workload and adjustment of assigned minutes.
- Flexibility on breaks and lunches
- staggered shift for weekend coverage

Outcomes:

- Monthly Quality Audit – N/A
- Budget – N/A
- Complaints N/A
- Staff Satisfaction: Although this unit has been through a major upheaval as described above, their People Pulse scores do not suggest widespread discontent. In fact, there were small increases in most of the unit's scores and a 9 point increase in the core staffing question. There were also some negative

trends including a 15 point drop for the question “my department seeks improvements to reduce costs”. The committee reported at the celebration day that there is more teamwork and more self-direction in the unit.

### Overall Assessment (AKA: Challenges)

The joint staffing process produced many incremental changes in actual staffing practices on patient-care floors and some improved outcomes for both patients and employees. Kathy Geroux, OFNHP President, argues that Joint Staffing is at least partly responsible for the very low vacancy rates for nursing position in the hospital and for the recent improvements in patient satisfaction scores. Another union representative, however, called it a “big, flat flop.” The project clearly fell short in jumpstarting broader partnership efforts at Sunnyside or in making significant changes in the organization of work. There appear to be several reasons for this:

Lack of leadership at the top and in some cases, departments.

There seems to be a consensus that the hospital CEO was not committed to the LMP. For instance, she dropped off of the hospital’s LMP steering committee. This cannot have provided a strong incentive for other managers to engage seriously in partnership projects. Further, in two of the non-patient care units that engaged in Joint Staffing, Dining Services and EVS, there were managers who not only didn’t support LMP but were viewed by workers and union leaders as authoritarian in their management style. All three of these managers are no longer working for KP; their removal represents a significant step forward for the LMP in the hospital.

There were problems, though of a different nature, on the union side as well. There was no clear labor sponsor within the hospital due, at least in part, to turnover. This meant, in the view of a top manager, that “there was not labor leadership willing to take accountability for jointly implementing the jointly agreed upon plans.” Labor leaders admit they gave insufficient attention to monitoring and organizing for the process. While the SEIU labor liaison was fully engaged in the process and clearly worked hard to prepare SEIU’s representatives for the meetings, OFNHP’s liaison was only a half time position and was, by some reports, not fully engaged. As a former OFNHP representative admitted, “we sent novices into a setting where management had a clear agenda”. At the national level, the union coalition found itself unable to provide sufficient support for the Joint Staffing pilots; according to CKPU Assistant Director Margaret Peisert, “We didn’t have or set guidelines or parameters around the pilots; we encouraged experimentation, . We encouraged local [projects] to share information, to look at data.” In fact, the inability to provide support and direction nationally eventually led the Coalition (along with KP) to remove Joint Staffing from the list of national LMP priorities.

## Failure to look at and resolve deeper, interdepartmental problems

The joint staffing process failed to address systemic problems that crossed departmental boundaries. Different examples of these types of problems were offered. Two deal with the ER: One observer noted that although the ER was able to reduce diverts through internal changes, more significant progress could only be made by freeing beds on the floors needed for transfers. In turn, that would require the ER to work with the staff from those floors which would almost certainly in turn require work with the pharmacy and other units that impact patient flow and discharge. A union representative pointed out that housekeeping was not involved in the patient care unit projects but that housekeeping is a key player: “In reality, if housekeeper issues aren’t addressed, the ER gets clogged up.” This same representative gave the example of getting an aspirin to a patient, and the need to eliminate some of the “millions” of steps in that process.

The failure to deal with systemic issues may have resulted in part from the structure of the joint staffing committees that were based within departments and limited in their functional representation with no representation from “service” units like housekeeping, pharmacy and dietary (with the exception of the 3S project). Further, the body that was tasked with dealing with “system” issues, the oversight committee, did not take them on. This seems in part due to both the labor and management co-chairs being unavailable due to significant leave time. In addition, the external consultant did not work directly with the committee after completed its charter. But the root of the problem probably stems from the lack of support from the hospital CEO. As one union leader put it, “They did the best the could do given the management leadership there.”

Perception that each party used Joint Staffing to move its own agenda rather than to solve problems:

If the unions failed to pursue their agenda within the joint staffing process, the same cannot be said of management. This is most evident in the focus on the Charge Nurse role in every nursing unit. According to one union representative, the Charge Nurse title was “jammed down our throats in [bargaining in] 96”; the evolution to dedicated Charge Nurses was thus viewed as part of management’s long term bargaining agenda and contrary to the spirit of partnership: “We didn’t want them, they’re another layer of management. We used to make assignments by consensus.” Other union leaders take a more nuanced view, arguing that OFNHP supports the way the expanded CN role has been defined in some units, but is concerned about that role developing into a “mini-manager”, especially given that the union hopes to begin moving toward self-managed teams.

Union representatives also argued strongly that management used the joint staffing process to push for 12-hour shifts, another piece of their recent

bargaining agenda. Unlike the Charge Nurses, members of staffing committees did not talk about this as a contentious issue, nor do the actual staffing plans suggest management was very successful in pursuing this. This may reflect OFNHP's successful "guerilla war" over this issue.<sup>5</sup>

A final example of the perception that joint staffing was used simply to pursue management's agenda comes from the Dialysis unit. The staff was convinced that management was simply pursuing its agenda of reducing their hours and eventually turning the entire operation over to the external vendor.

Similarly, at least some managers, (and to some extent the consultant cited above) viewed the union as being focused solely on increasing staff levels, whether or not there was a business case for additions. For example, one manager argued that "departments took all the staffing FTE improvements . . . and quickly implemented those as they were not at all controversial; they did not implement the other aspects of the total staffing plan that required changes in practices." Further, "the hidden labor agenda seemed to be 'get more staff, there is no other solution'." Union representatives deny this just as management representatives claim they had no hidden or past agenda.

#### Failure to really use Metrics and to be self-critical

From the national agreement on down, all enabling documents for joint staffing call for tracking or measuring outcomes. Measurement was part of each joint staffing plan. However, there was a little actual tracking of the predetermined measures. In most cases, there was no circling back to the measures until the "Celebration Day" in November 2003 and even then, most units did not collect or present all of the measures they had originally listed. In some units, management had looked at some of the data, but had not shared it with the staffing committee. In retrospect, some units had not necessarily chosen their measures well, for example 1 North had listed "patients turned away" as a measure but it was not available. And even where there were improvements in the metrics, there were often other potential explanations for those improvements aside from the staffing changes. For instance, patient falls dropped on 1NW, but a more likely explanation than the staffing changes was the purchase of Ambulatory Alarms. Or in the Dialysis unit, a new service was begun around the same time as the staffing project, complicating the measurement of some outcomes. Finally, in general and with the clearest exception of the manager of the Dialysis unit, the managers involved were very upbeat and positive about the joint staffing process, while the metrics did not tend to support their assessments. In some cases, they argue that it is simply too early to see changes in outcomes.

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<sup>5</sup> According to Alan Moore, internal organizer with OFNHP, the union advocates for 10-hour shifts for a variety of reasons, including that they cause fewer scheduling problems (e.g. break coverage) and are safer for workers and patients.

## Other issues:

### Uneven implementation

1. While a lot of time and effort were spent in creating the staffing plans, less effort seems to have gone into implementing the plans. Virtually all the plans suffered from uneven or incomplete implementation. Some were simply not implemented at all. At least some of this problem is a function of the problems with the Oversight Committee. It's worth noting that there were problems in implementing plans in the Joint Staffing pilots in other regions.

### 2. Poor choices for initial projects

Of the eight units described above, there was good reason to believe that at least three were deeply troubled and might have difficulty with the joint staffing process. This includes 1 South, the first unit to go through the process. (The other two were EVS and Dining Services.) While the unit was chosen, at least in part, precisely because it needed the help, it is usually important to demonstrate clear success when beginning a change process of this nature. On the other hand, several informants reported that the parties, especially the unions, learned a lot from the 1 South experience, lessons that were then applied successfully in the other projects. OFNHP is hoping to "circle back" to 1 South and "redo" the staffing plan for that unit.

### 3. Improved relations within teams

On the positive side, there is considerable evidence that relations among committee members improved through the process. Many of the interviewees reported such improved relationships. A survey that was conducted internally within the units that had gone through Joint Staffing also provides some support for this conclusion, mainly in the comments in response to the question "What went well?". (The response rate and overall sample size for this survey was so low that it is not a very useful evaluation tool in general.) "Higher self-esteem for those involved, higher responsibility for everyone's welfare." "I feel we communicated and deliberated well enough to figure out what we need to fix." "Working through staffing issues together." "The Joint Staffing team worked well together." Unfortunately, there is little evidence that this good feeling extended beyond the team itself.

### 4. Constituency communications/relations and the representative model

Virtually all of the departmental committees had problems with relations with their constituencies. This is despite that fact that all implementation plans were supposed to include, and often did, communications plans. Most groups reported that they had tried to reach out to non-committee members to get input on the issues and reactions to proposed changes. Still, they were often met with

suspicion and hostility from co-workers. This problem is reflected in comments from the internal Joint Staffing survey mentioned above. Suggestions for improvements in the process included “Maybe regular meetings to better inform staff not committee of how the project is going.” “More people involved.” “Preparing those on the committee for employee backlash when it involves changing schedules.” “Relaying of information. Asked same question by different people, unsure if it got passed on and feedback varied from person to person.” “More communication with everyone on what is going on.” This problem may also go some way to explaining why the People Pulse scores do not show any systematic improvements.

Some of this problem may have resulted from insufficient representation of occupational groups or informal networks within units. 1 South’s initial draw of the Joint Staffing Team from the Unit Based Council assured that non-Charge Nurses and other occupational groups would be under-represented helped to get that process off on the wrong foot. Dining Services was factionalized and members of one faction were left of the team causing resentment.

At the same time, some of the problems arising between representatives on committees and the workers in a particular work unit may result from failure of workers to accept peer representation in this context. As one committee member put it, “just because we didn’t decide what you wanted to have happen, doesn’t mean we didn’t talk about your issues.” Similarly, some managers argued that workers and perhaps some union activists have not yet accepted the representative model: “the culture of labor still does not embrace a representational model of governance; any individual can still just say ‘no, I’m not going to do that’ and without labor support the manager cannot make it ‘stick’ without looking authoritarian.”

#### 5. Role of Physicians:

There was little involvement of physicians in the Joint Staffing process. A physician was involved in a substantive and ongoing, though still spotty, way in the process in only one of the patient care units. Unit managers tended not to see this as a problem, arguing that physicians had little to contribute to staffing decisions. This view may be related to the fact that most of the staffing plans were limited in scope and did not deal with deeper, interdepartmental issues as described above. 1 South, for instance, clearly identified issues related to physicians, but these were part of a long list handed off to the oversight committee. In the unit where a physician was most involved, that involvement was a double-edged sword. On the one hand, they were able to contribute the perspective of their constituency. On the other, they were perceived as part of management, as pushing management’s staffing agenda.

In general, workers and union representatives, and to a lesser extent frontline management, are interested in physicians becoming more involved in the LMP. As one nurse put it: “It would be better if they would buy into the

partnership more. . . I've spent 15 years in the department and I know most of the doctors very well. I feel comfortable talking directly with them. I think there's been a change in the attitude, less of a team effort now. It's us and them. . . It used to be a very good team. Doctors and nurses got along well when there was some down time. I thought there was productive discussion, there was encouragement to work as a team. I don't see that now." The hope is that the LMP could bring back that sense of teamwork. An OFNHP staffer reported that the union has "held [physician involvement in the ED joint staffing process] as an example of what is possible and [has] worked to entice the physicians to fully engage with us and management in the LMP."

### Future Directions

It is important to note that the Labor-Management Partnership in the Northwest Region and at Sunnyside has come a long way since the Joint Staffing process was first begun. Many of the leaders in the facility and the region argue, convincingly, that much was learned from the Joint Staffing experience and that they could not be as far along as they are today without that experience.

The region, under the leadership of Cynthia Finter is considered by leaders of the union coalition to be one where LMP is a true success. Regional leadership, both labor and management, has pursued a partnering approach to the LMP, where all mid-level managers and above are in the process of being partnered with union representatives from each of the coalition unions representing workers under the particular manager. The region underwent a major restructuring in Spring 2004. Some managers who had failed to embrace partnership did not survive the restructuring. Labor representatives participated in the restructuring process and are participating in the major, strategy-setting managerial bodies in the region. The restructuring itself, according to Regional President Cynthia Finter, had a number of goals and motivations, but at least one of those was to create an organizational structure that was easier for labor to partner with.

While most of the labor partners are released for 4 hours per week for their partnership activities, the new CEO of Sunnyside, Jesse Gamez, has a full-time labor partner, Guy Marx. (Marx is a member of OFNHP and had worked as a nurse at KSMC, including as a Charge Nurse in Emergency. At the time he became the labor partner, he was working the region's nursing Call Center.)<sup>6</sup> Following Gamez' transfer to Sunnyside, and after separate labor and management retreats, labor and management held a joint, two-day retreat in Spring 2004. At this retreat they reached agreements on LMP structures and goals for the hospital. The parties planned to move away from the separate LMP

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<sup>6</sup> At the time of this writing in December 2004, Marx was planning to return soon to his Call Center job and was just beginning the transition with his replacement.

Steering Committee to integration of labor representatives into the Hospital Operations Tracking Team (HOTT). Similarly, the Unit-Based Councils, a source of considerable labor-management trouble, were to be “switched” into LMP structures. As of October 2004, about ½ of the UBCs had been transitioned and labor representatives were added to the HOTT. Further, two new labor partners, one each from the SEIU and UFCW locals at the hospital are now working with Gamez. Further still, a Steward’s Council, with representatives from all of the Coalition unions in the facility has been meeting regularly.

Marx views the early Joint Staffing work at Sunnyside as the beginning of the process, as an “introduction [for labor] to managing your resources”. In addition, “there was some team building that was kind of an accidental fallout.” Similarly, Kathy Geroux, OFNHP President, reports that her members at Sunnyside report very positive feelings from the Joint Staffing projects. Marx’s vision for the future, consistent with the direction of the LMP at the hospital, is that Joint Staffing would cease to be a separate initiative. Rather, each LMP departmental committee would review its staffing matrix each year and look for where change needs to happen. In addition, there would be other structures to can work the inter-departmental issues that have yet to be dealt with. The new multi-union Steward’s Council could be one vehicle for this. Or departmental LMP committees could come together to meet on issues that cross boundaries.

In the meantime, there are at least two ongoing projects being undertaken that begin to deal with interdepartmental issues. Both of these are IDEO<sup>7</sup> projects – one focused on communications across nursing shifts and one focused on “bed management” – and cover some of the same ground as the Joint Staffing process. Union and management leaders have discussed other system-focused projects, including a possible revamping of the pharmacy operation to take advantage of the physical relocation of outpatient clinics out of the hospital. This relocation will free up pharmacists from other duties and would make them available to deliver discharge medications to patients in their rooms. This would ease and speed the discharge process since patient family members have traditionally had to travel to the pharmacy to collect medications (and to various offices to deal with paperwork) and will give pharmacists an opportunity to educate patients and their families together on their medications. This idea is an example of exactly the kind of fundamental change that the unions were supposedly looking for out of Joint Staffing. However, it was not clear where it was going to go given the Pharmacy Guild’s non-participation in the LMP and their apparent disinterest in changing the way they do business. Despite these issues, Gamez admits that the systems issues are “still a gap” and will be the focus on the next LMP retreat early in 2005.

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<sup>7</sup> IDEO is an approach to change and innovation offered by a consulting firm by that name. It emphasizes incremental, rapid change. The nursing communication project is a multi-regional project including staff from four KP hospitals including, in addition to Sunnyside, one from N. California, S. California and Hawaii.

While joint staffing is a window into the development of the LMP both in Sunnyside and in the region, it was also originally, but is no longer, a national LMP priority. As noted above, this change in status was largely a result of the union coalition realizing it could not provide adequate support to Joint Staffing on top of all the other initiatives called for in the LMP implementation plan. This is not to say that the union coalition's commitment to work on staffing problems has diminished, rather they are being pursued locally through other LMP vehicles. At the same time, this lack of national direction and support on the union side may be one reason for the somewhat weak performance of the Sunnyside project.

## Conclusion

While there are some grounds to argue, as some do, that the Joint Staffing project was a failure, it is not quite that simple. Some good things did come out of the project, including some additional staff positions, some changes in practices and some improved relationships. Perhaps more important is that many of the parties involved feel like they learned a lot from the process, including lessons about the appropriate representatives for the workforce, communicating with constituents and the problems of LMP efforts that are not embedded in regular management structures. At the least, one can see the staffing project as the beginning of LMP in the hospital, as a sort of placeholder while more LMP friendly managers were put in place and a full-time labor partner was hired. While Joint Staffing may have been expected to jump start the LMP, that was probably a tall order given the management-side reluctance and lack of labor preparation and organization.

Sunnyside People Pulse, Changes in Positive Answers from 2002 to 2003 - Selected Questions

	Sunnyside Overall	1 South	1 North	1 NW	Emergency	Dialysis	Food Services, etc.	Environ. Services (House- keeping)
Influence Index	4	-9	-7	18	4	-7	-27	0
Care Experience Index	6	0	7	4	-6	15	-9	-1
Recommend KP as place to work	7	3	23	-12	-5	26	12	6
People I work with cooperate to get work done	-6	-26	-11	-22	-9	12	-16	5
People in my dept work together to deliver good service	1	-17	8	-30	-13	0	11	7
<b>There are enough people in my dept to do the job well</b>	9	-5	27	1	-3	-1	-35	9
My dept seeks improvements to reduce costs	1	-12	17	12	1	12	-21	-15
The hours I work are* --too few	0	1	-18	0	-9	29	14	0
--too many	-2	1	9	0	7	0	-14	-1
When ees have good ideas... mgt uses them	6	-17	17	-8	2	-33	-35	8
I have influence about how things are done in my work group	2	-34	-1	14	-6	-13	-12	6
How much say/influence over decisions affecting your work	6	8	-21	9	2	-15	-29	-4
LMP Questions								
How much do you know about LMP	6	12	9	27	-1	43	-16	13
Personally involved in LMP	6	13	-13	20	-9	18	7	-9
LMP has helped me become more involved in decisions that imporve work environment	3	25	17	15	5	0	-14	9

\*Note: Negative trends are desirable on these questions unlike others

**Changes to Pulse Staffing Question for Departments involved in Joint Staffing**

