Turning Around Kaiser Permanente Ohio through *Labor–Management–Physician* Partnership

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At the start of the new millennium, the Kaiser Permanente (KP) Ohio Region was like a boat caught in the perfect storm, in an intersection of forces that seemed poised to capsize it. Ohio had suffered industrial decline and employment losses for several decades. Tens of thousands of jobs disappeared in the steel and auto industries, and new job-market entrants were going where there was work, not to northern Ohio. As a result, the population of the Cleveland area, the center of KP Ohio's market, was declining in numbers, economic status, and health.[1] In addition, Ohio had historically been more receptive to traditional healthcare programs and not to the health-maintenance organization (HMO) model that Kaiser Permanente pioneered in the Western states.[2]

Kaiser Permanente is distinctive as a fully integrated care delivery system: it provides and coordinates its patients' care across a full range of services. The KP Ohio Region provides primary care and outpatient services, and contracts with area hospitals for inpatient services for its members. KP is also unique in that it operates under a historic Labor–Management Partnership agreement established in 1997 between the organization and eight international unions.[3] Labor signatories to the Partnership formed the Coalition of Kaiser Permanente Unions (CKPU) to create a coordinated unit for working on Partnership matters. The Partnership's goals jointly commit labor and management to improve the quality of care for patients, the quality of work life for employees, and the financial performance of the organization.

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Joint Leaders Champion Change

Kaiser Permanente and its affiliated unions in Ohio were determined to overcome the forces storming the Ohio Region. KP named a new president of the Kaiser Foundation Health Plan of Ohio in July 2002. She and the president of the Ohio Permanente Medical Group, the physician practice, agreed with the national director of the CKPU and the local president of the Office and Professional Employees International Union (OPEIU) that the challenges facing KP Ohio required a new approach to a turnaround. "Turnaround" in many organizations would mean a flurry of pink slips and layoffs, but not in a Partnership organization.

The four leaders decided that labor, management, and physicians would jointly redesign the care delivery system.

While the leaders were developing an understanding of how the Partnership would function in the turnaround effort, the "change train" had already left the station in some parts of the organization and was picking up steam. Managers responsible for annual planning and budgets had already embarked on restructuring and believed there was no time to spare. They also believed that the addition of labor representatives would slow the change process, and were uncomfortable with potential delays.

The leaders held firm to their commitment to joint work on the change initiative, and in January 2003 the Region held its first Labor–Management–Physician retreat. The retreat of about thirty people included the four leaders, the people reporting directly to the presidents of the Health Plan and Medical Group, two senior labor experts "on loan" to the Ohio project from the CKPU and another Partner union, and the officers of the OPEIU local. The purposes of the retreat, facilitated by Restructuring Associates, Inc. (RAI), were to educate the participants about the Labor–Management Partnership, build understanding of the parties' respective interests, and share the business case for change with all three constituent groups. It was also a forum for identifying issues and concerns that the change initiative would have to address.

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Labor was clear that its members would not bear the cost of change alone. Physician leadership wanted to ensure the retention of caregivers, sound treatment protocols, and a strong commitment to the adoption of new technologies. Managers emphasized the need to keep quality and cost in focus. All parties were intent on being true to the KP mission of service and integrated care, and everyone questioned how the parties' interests could be served while making significant change happen in a very short time.

Care Delivery Redesign

The leadership retreat launched the joint change initiative with the following goals:

- Restructure care delivery processes at the work level to improve the patient experience;
- Align the Region's capacity with demand, and position the organization for the future; and
- Develop a hospital and network provider strategy consistent with the KP continuum-of-care approach.

A Work Redesign Conference was chosen as the centerpiece of the restructuring.

The presidents of KP Ohio and the Medical Group, and the national director of the CKPU became the sponsors of the initiative. They set aggressive time frames for the project groups: implementation needed to begin by the third quarter of 2003. Their timing was driven in part by the challenges that needed to be addressed. They also recognized, however, that a large number of people would be involved, including frontline staff, and that patients still had to be seen in the clinics and on hospital rounds. The project work had to be done intensively, thoroughly, and in a compressed time frame so that clinical staff would have minimal time away from patient care. RAI was asked to lead and facilitate the process.

Ambulatory Care Redesign and the Conference Model

An Ambulatory Redesign Group (ARG) was given responsibility for matters pertaining to outpatient care, with a manager, union leader, and physician as joint chairpersons. The ARG met regularly (about one to three days per week) between March and June of 2003. By early April, after joint analysis of the existing system and its performance, the ARG accepted the principle that substantial gains in effectiveness would result from new work structures and new ways of organizing work. After reviewing multiple options, the ARG chose a Work Redesign Conference as the centerpiece of the restructuring.

Conference models are typically large-scale, participative workshops with a clearly defined outcome, sometimes described as bringing "the whole system under one roof." The ARG planned to do just that, and, in the process, promote change that was implementable, sound, and sustainable.

The ARG Conference planners were committed to honoring LMP Partnership principles, such as full information sharing, a focus on interests, and consensus decision making. They also wanted the conference to foster innovation. To accomplish all of this, the ARG identified 115 physicians, staff, and managers to participate, assisted by five RAI and two internal consultants, and set aside three weeks during July and August for them to convene.

Management agreed to release union members from the front line to participate, and the union ensured that release commitments were honored. The CKPU representatives and local union officers held steward meetings to provide company financial information and project status updates, to examine the potential impact on frontline staff, and to discuss how to handle questions. Physician schedules were adjusted sixty days in advance in an effort to provide ample appointment times around the project schedule and to avoid inconveniencing patients.

The ARG functioned as the steering committee for the conference. It organized conference participants into four teams, each with management, labor, and physician representatives appointed by their leadership. Two teams focused on patient-facing issues: Practice Settings (clinical departments) and Practice Effectiveness (ancillary services such as laboratory, radiology, and pharmacy). Two other teams dealt with administrative and internal overhead questions, and with referral practices.

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After an initial day and a half of background briefings and training in Partnership principles and group processes, a Practice Settings plenary session addressed "macro processes" that affected all the clinical departments. These processes included issues such as the nursing model and clinical support roles, among others. After consensus was reached on these issues, ten clinical department teams, ranging from three to fifteen members each, commenced work.

Recommendations and Implementation

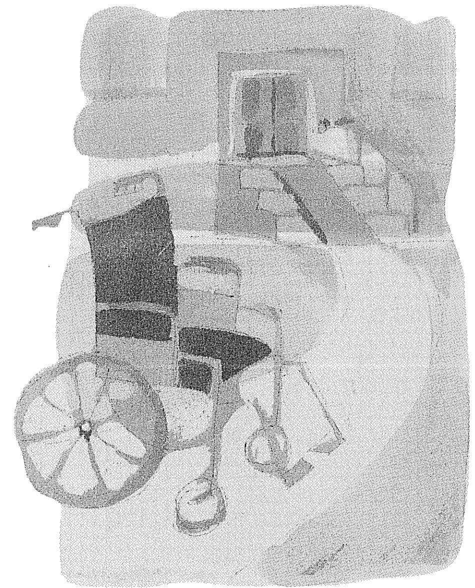
By the end of the three weeks, the four conference teams produced 141 recommendations with an implementation plan for each, which then went to a joint review committee and ultimately to the joint sponsors for approval. In October 2003, seventy-one recommendations were approved, fifty-six were pending additional analysis, and seventeen were rejected. Recommendations varied in complexity. Some involved broader policy considerations, but the conference primarily provided a joint forum for airing and testing ideas to improve day-to-day performance. Here is a sample:

The conference provided a forum for airing ideas to improve day-to-day performance.

- Reassigning accountabilities among registered nurses, licensed vocational nurses and medical assistants to leverage the full scope of licensed staff capabilities;
- Investing in the expansion and improvement of operating-room space, and restructuring surgery schedules to improve utilization; and
- Revising physician appointment schedules to minimize travel time among hospitals and KP clinics.

In early 2004, a second phase of ambulatory redesign (also facilitated by RAI) was undertaken for the departments not included in the first phase. A reconstituted, smaller, joint ARG provides ongoing oversight to ensure that implementation continues, and a project manager was hired to manage day-to-day implementation of the approved recommendations. The employees, physicians, and managers who participated in the redesign seeded the departmental labor–management committees that were created to implement the approved recommendations. These people had acquired a level of participative competence enabling them to be active "organizational citizens" through their involvement in the labor–management–physician partnership.

The project was successful in accomplishing the care delivery redesign objectives originally put forward by the sponsors and ARG co-chairs. Once implementation was underway, conference recommendations amounted to almost a 7 percent improvement in the operating budget. Equally important is that they began to produce changes in staffing, workplace climate, work structures, and clinical and service processes that the sponsors and co-chairs agree will improve KP Ohio's quality, service, and financial performance, benefiting all its constituents.



Notes

1. In late 2004, Cleveland had the unfortunate distinction of being named the "poorest big city" in America.
2. Kaiser Permanente is the nation's oldest and leading not-for-profit health-maintenance organization, serving 8.6 million members—80 percent of whom reside in California.
3. For more information on the Labor–Management Partnership, visit http://www.LMPartnership.org.

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