

The Labor-Management Partnership: An Interview

In 1998, Kaiser Permanente (KP) entered into the Labor-Management Partnership with the Coalition of Kaiser Permanente Unions to unite around common purposes, to work together to most effectively deliver high-quality medical care, and to prevail in a fiercely competitive health care environment. The Coalition of Kaiser Permanente Unions includes eight international union partners and 25 local union partners; together, these unions represent about 65,000 KP employees in most KP Regions. Labor-management partnership organizational structures—where management and unions work together to address operational issues—have been established in a number of facilities, most notably the new Regional Laboratory in the Northwest Region, the new openings of KP Baldwin Park and Roseville Hospitals in California, and The Permanente Medical Group's Northern California Optical Laboratory, which has moved from the brink of inefficiency-related closure to new highs in both productivity and revenue. Last year, for the first time, the partners negotiated common issues nationally across KP Regions and unions. Both the partnership and the negotiation process have been popularly described as the largest and most complex labor-management partnership effort in the country. This effort is currently led by the Labor-Management Part-

nership Strategy Group and the National Partnership Council.

To discuss the Labor-Management Partnership, TPJ sat down with three key members of the Partnership's Strategy Group: Peter diCicco, Executive Director of the Coalition of Kaiser Permanente Unions; Oliver Goldsmith, MD, Medical Director of the Southern California Permanente Medical Group; and Leslie Margolin, Senior Vice President for Workforce Development. The text of the interview is presented here.

Annette Bremner for The Permanente Journal (TPJ): Although the Labor-Management Partnership is entering its fourth year, not everyone is clear on what it is or why we entered into it. Would you comment on the benefits, and challenges, of the Partnership?

Oliver Goldsmith, MD: To me it is very simple: the improvement in KP's performance can only go so far unless everybody is engaged equally in trying to improve the organization. We've made some significant progress through a variety of initiatives, but in my opinion we're still



To me it is very simple: the improvement in KP's performance can only go so far unless everybody is engaged equally in trying to improve the organization.

Annette Bremner, MEd, MPA, Communications Manager, National Labor-Management Partnership, Kaiser Permanente National Program, Oakland, California, conducted the interview.

performing at maybe 70% of our potential. Perhaps we can bump that percentage up a few points through efforts similar to the ones we have initiated in the past. But we can't reach our full potential unless our employees are participating much more energetically in these efforts. To accomplish that, we must involve them and bring their leadership and their unions on board. By working in a partnership model, we will more clearly understand their needs, and they will have a better understanding of our needs as physicians and managers. It is similar to the way that we in the medical groups work in collaborative partnership with our Health Plan and hospitals.

Peter diCicco: I think what Oliver has said is absolutely correct and is underlying the whole premise around what the Labor-Management Partnership is about. We have known for years that the best way to get quality of care and improved financial performance and improved safety and improved overall morale is for people to feel that they are fully engaged and are making a contribution that's meaningful to the process. That's what the partnership is about. That's what our objectives are.

Leslie Margolin: A slightly different observation about it is that in my judgment, people come to KP—or most people come to KP, because they believe in our mission and



our values and our purpose. The opportunity that's presented by the partnership is to really give us the opportunity to capitalize on that in terms of engaging people's hearts, in terms of asking for their opinions and help, in terms of how we can improve our performance and valuing our employees for the contributions that they make.

TPJ: All of that sounds wonderful. So why is the partnership still looked at with skepticism by some and not known or understood at all by others?

Leslie Margolin: Our greatest challenge has been what we call capacity building—that the Labor-Management Partnership engages management and frontline workers across the organization, that it's understood by and felt by our physicians and by union leaders. You can't just throw people into new working relationships and expect them to behave differently. So a lot of the effort up until now has been invested in making certain that employees and union leaders who are participating in our governing structure, and some of our decision making models, are in fact knowledgeable of our business, and business fundamentals. And that the management people become more knowledgeable of union needs and issues, so that all of us are familiar with and comfortable with the principles of partnership. How far this has rolled out in the organization varies by KP Region and Service Area because they all started at different levels of understanding and had various experiences in trying to work together.

Oliver Goldsmith, MD:

Leslie is quite correct about the behind-the-scenes efforts. In '97 and '98—when the Labor-Management Partnership was being launched—I didn't spend a lot of time talking to the physicians about the Labor-Management Partnership. To me, it was a senior-level thing going on then in terms of my own activity, so except mentioning it to our medical group board now and then, I wasn't out beating the drums about it. Quite frankly, I know physicians find flavor-of-the-month programs tedious, and I wanted to wait until there was more tangible progress to talk about rather than attempt to sell concepts that to some would sound like motherhood-and-apple-pie wishful thinking. Physicians generally expect new concepts to be accompanied by supporting data. We now have successes and supporting data to point to.

Peter diCicco: While we're not there yet, we're sharing a common objective to get it into each and every facility so that everybody in the organization is participating.

TPJ: So you believe there are tangible results to point to now?

Peter diCicco: I think that the national bargaining last year—the first-ever effort at concurrent negotiations on 33 contracts with 25 unions and in most KP Regions—was a watershed, where we moved from one environment where people were really waiting to see if this was going to be a longstanding success to one in which we now see an awful lot of progress.

Leslie Margolin: I would agree—and when I say that I

When you start talking about improving retention and availability of experienced support staff, reducing the risks of being needle stuck with hepatitis or HIV, and reducing the loss of RNs during the current nursing shortage—these are issues that are very real to physicians, because these issues affect their ability to practice medicine and the smooth operations of their practices.

think Peter would agree with me—that it is not because of the contract itself but the process that got us there.

Peter diCicco: Absolutely, because it was during the national bargaining and the work of the bargaining task groups we found out that there are a whole series of areas where union and management, frontline worker and manager, have mutual interests. Areas to examine that go beyond just simply financial improvement as a single focus but include mutual desires to improve quality of care, quality of service, workplace safety.

Oliver Goldsmith, MD: I think the initiatives rolling out of the Health & Safety Bargaining Task Group are most likely to capture our physicians' attention. When you start talking about improving retention and availability of experienced support staff, reducing the risks of being needle stuck with hepatitis or HIV, and reducing the loss of RNs during the current nursing shortage—these are issues that are very real to physicians, because these issues affect their ability to practice medicine and the smooth operations of their practices. Sure, we're all interested in the financial benefits as well, but we physicians are just as human as anyone else. The bottom line is how will it benefit

me directly. There are some significant ways these initiatives can help physicians and patient care. Plus, the results will be measurable. Physicians always want data, and these initiatives have specific targets and ways to measure whether we meet them.

TPJ: Could you talk a bit about these initiatives—what they are, how they came about, when physicians can expect to see them implemented?

Peter diCicco: As I mentioned earlier, part of the big breakthrough in the national bargaining was that the bargaining task groups—frontline employees, managers, and union leaders working side by side—began to discover they had some mutual interests above and beyond the normal “money” issues of traditional bargaining. And once they started identifying the end results they really wanted to achieve, they found they weren't too different and that there was room to be creative. So, for example, rather than talking about how to save money around workers' comp, the challenge became to prevent injuries in the first place. So now there is a clearer focus on the ultimate goal, and we're initiating a major initiative this year around workplace safety—safety for employees, for physicians, and

for patients. And it's not just a matter of focusing on the financing but on how we actually prevent injuries. What can we do to assist injured employees to return to the workplace quicker—for their own economic and physical well-being but also to improve continuity of service and support.

Leslie Margolin: The data the Health & Safety Bargaining Task Group put together indicated that one employee in eight will have an industrial injury or illness requiring more than first aid, and 1 in 20 will sustain some level of disability as a result. Nationally, large companies are spending more than 14% of their payroll on disability costs. We think KP's experience is similar, which would amount to approximately \$500 million a year.

Oliver Goldsmith, MD: But of equal importance is the ability to retain caregiving teams by preventing injuries and by expediting the return of employees from disability. Data presented by the Bargaining Task Groups indicated The Permanente Medical Group in Northern California has been able to increase work hours of their clinical support staff by 10,000 hours annually through an improved approach to integrating workers' comp services alone. To me, that translates into more efficient clinic operations, better patient care, and happier physicians.

Leslie Margolin: The program Dr Goldsmith is talking about also resulted in an annual cost savings of \$5 million. In KP Northern California, The Permanente Medical Group's



Average Indemnity Claim Cost appears to have remained flat while it was rising by about \$8000 statewide in California. The Health & Safety Bargaining Task Groups estimated that 1000 more employees could be returned to work by working with them to accommodate their work limitations. And \$50 million annually could be saved—and services improved—by eliminating redundancies in our disability system, as Northern California did.

TPJ: Is this the primary thrust of the initiative on workplace safety then, or are there others?

Leslie Margolin: It is only one aspect. Another focus is back injuries. The single most common and expensive workplace injury is overexertion of upper extremities, including back injuries. And we will be rolling out a three-pronged program to reduce them, including improved training in patient handling, development of patient-handling lift teams to assure adequate staff on hand, and purchase of additional vertical lifting devices where appropriate. We are projecting reductions of 10% to 70% in back injuries over the next three years.

Peter diCicco: I believe the whole area of “needle sticks” is another good example of where some creative thinking complemented existing efforts and is being broadened under this initiative. There was a “Sharps Committee” as an offspring of the KP National Purchasing Council, to make recommendations on what types of needles to buy. But the needle itself is only one aspect of the risk. So the “Sharps Committee” has been reconstituted as

a partnership committee, and will be kicking off later this month. In fact, by the time this publication comes out, I think the initial training and meetings will have already taken place. The scope has been broadened in terms of participation programwide and from management, employees, and the unions. It’s a whole new approach, and coupled with the workplace safety initiative, we can see that there is really a major thrust on the part of the organization to seek significant improvement in this area.

TPJ: Is there physician involvement in these Labor-Management Partnership committees and task forces?

Oliver Goldsmith, MD: I, and other medical directors, have not put physicians on many regular committees. That is not due to a lack of interest, nor a feeling that we haven’t anything to contribute. It is simply the reality that patient care has to come first. We don’t have the luxury of physician time to put into many of these positions, because then there are some 30 patient appointments a day being canceled. There are paid medical group administrative staff participating, a few physicians in key roles, and of course the Permanente Medical Group Medical Directors are involved nationally at the senior partnership level.

Leslie Margolin: Let me just echo a point we made earlier in that it is not just the time of the meetings itself. All the members of a committee or task force must go through partnership training to learn how better to work together to resolve issues, reach common understandings

on fundamental business and union practices, etc. It is a major time commitment.

TPJ: Are there other aspects of the workplace safety initiative you would like to address?

Oliver Goldsmith, MD: We have alluded to the element of patient safety, but I would like to be a little more explicit. We physicians all took an oath: “primum non nocere,” or “first, do no harm.” You may not be able to help the patient, but do no harm. Yet there is no physician in America or in the world who hasn’t seen harm done to an employee, a physician, or a patient through something that happened that shouldn’t have happened. We need to address how we can improve patient safety as well and eliminate anything that places a patient at risk. Physicians sometimes react against such an initiative, because it has a bureaucratic ring to it. But it doesn’t have to be looked at negatively. The safety of our patients requires optimal performance, eg, the arrival of a surgical kit on time, the availability of a room, the availability of an appointment. It’s much broader than just giving the wrong medication or something that has a negative connotation. And so all of these [aspects] require the focus of everybody in the organization. That’s kind of the sense I give to it. We need to find a way to engage everyone in that effort.

Peter diCicco: What we’re doing through the Labor-Management Partnership is to create one or two pilots in place that will begin to encourage those types of input from physicians and nonphysicians. The

intention is to look for full input from people and that they give it uninhibitedly—where the goal is not finger pointing but creating an environment where people really feel comfortable in being able to come forward, and be open and candid in how we correct problems. And I think where we have tried it, we’ve been able to demonstrate that, in many cases, the problems are systemic and are easily corrected. That’s not to say that, if we have negligence, the individual responsible for negligence shouldn’t be scrutinized and, in fact, action taken. But in many cases, we find out that there are systemic problems.

Oliver Goldsmith, MD: At the risk of heresy, I think we physicians need to acknowledge that we don’t know it all—that there are many things happening around patient safety that simply are beyond our horizon of activity. Physicians see you in the office, then go to the next patient. Their minds are focused on that, and very little else. So, physicians need to encourage employees to come to them and say, “You know, I know you want this to happen, but it doesn’t happen—because when the patient goes to the second floor, the railings aren’t up”; or “the beds aren’t made correctly”; or whatever it may be. So the physician has to be alerted to a broader dimension to quality of care. It is more than, “You take this pill and you will be better.” The challenge is much broader than that.

Peter diCicco: Right, and they [these employees] are the ones who can contribute most signifi-



cantly to creating the environment for people to come forward and provide leadership in systemic improvements. They set the tone, so it is a nonpunitive approach to correcting systemic problems rather than bickering and finger pointing.

Oliver Goldsmith, MD: I can see a physician at a meeting saying, “Look, here’s what we want to happen. Is everybody comfortable that this is what’s going to happen? When I discharge a patient from the hospital, to get them into their car,

does this happen smoothly?” And then, instead of obsequious head nodding and muttering behind physicians’ backs, there is an outpouring of “No, there’s not enough this, that, or the other thing,” with constructive ideas for how to make it work. Then we will have achieved partnership, and I sincerely believe all of our jobs will be easier.

Leslie Margolin: If only it were that simple. But one thing we’ve learned over the past four years is that everyone has

to invest time and energy into really listening to and understanding one’s partner. It takes a while to set aside past suspicions and skepticism and learn to listen with open ears. But the payoff can be immense, as we’ve seen in the KP Regional Clinical Laboratory in Northern California. Although the workers were initially skeptical about how talking about safety would accomplish much, they reduced lost days by 90% last year once they got into the safety program. And the safety

program only cost 10% of the workers’ comp costs. That is the kind of win-win that the Labor-Management Partnership is all about—improved health for our employees; increased efficiency and production for our patients and members.

TPJ: Thank you all for your time and insights. ❖

Acknowledgment

Robert A Hughes, BA, Retired Associate Director of Public Affairs for Kaiser Permanente Northern California, edited the contributions.

One Day at a Time

The best thing about the future is that it only comes one day at a time.

Abraham Lincoln, 1809-1865, politician and statesman, 16th President of the United States