

# THE KAISER PERMANENTE LABOR MANAGEMENT PARTNERSHIP

## THE FIRST FIVE YEARS



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# **The Kaiser Permanente Labor Management Partnership: The First Five Years**

**Susan C. Eaton, Thomas A. Kochan and Robert B. McKersie**

## **Executive Summary**

This case study analyzes the evolution of the Labor Management Partnership at Kaiser Permanente from its inception in 1997 to June 2002 and identifies a set of critical issues and challenges the parties will face in moving forward. The study, and a parallel case analysis of the interest-based bargaining process used to negotiate the 2000-2005 labor agreement, constitute the products of the first phase of our research on the Partnership. The next phase will track the effects on performance outcomes of Partnership initiatives underway in specific workplaces.

### **Background and Methodology**

Leaders of the Labor Management Partnership requested that we conduct this study to (1) provide an independent review and public documentation of their experiences over the course of its first five years, and (2) identify challenges and opportunities facing the parties at this stage of the Partnership's evolution. To do so over the period of June 2001 to June 2002, we have interviewed approximately eighty management and labor representatives, physicians, and facilitators involved in the Partnership. Interviewees were asked to describe their experiences with the Partnership to date, assess the Partnership against the expectations and goals set for it, and identify the issues facing the parties as the Partnership moves forward. Interviewees were assured that their views and comments would be held confidential and that we would only attribute statements to them with their permission. In March 2002, a preliminary draft was circulated to those quoted. Additional interviews were then conducted and revisions to the draft were made based on feedback and factual corrections and clarifications offered by labor and management representatives. In addition, we have reviewed the large volume of documents the parties have collected to record their work and experience to date and the results of the People Pulse surveys (Kaiser Permanente's internal employee survey) completed in March 2000 and again in March 2002. We also have attended two meetings of the National Partnership Council.

## **Pivotal Events**

Experience indicates that strategic Partnerships such as this periodically encounter what we term “pivotal events” which pose challenges that, if successfully addressed, serve to strengthen and reinforce the Partnership and broaden its base of support within the participating organizations. If not managed successfully, these pivotal events often lead to the demise of these efforts. The most salient pivotal events in the Kaiser Permanente Partnership to date include:

1. Signing of the initial Partnership Agreement in 1997.
2. Agreement on Employment Security Principles.
3. Creation of a Structure and Interest-Based Process for National and Local Negotiations.
4. Negotiation of the 2000-2005 Bargaining Agreement.
5. Use of the Partnership principles and processes in several highly visible workplace projects such as at the Baldwin Park Hospital and the Northern California Optical Laboratory.
6. Transitions in top management leadership in Kaiser Permanente.

## **Achievements to Date**

The agreement to create this Partnership is itself a noteworthy development. This is the largest and most ambitious labor management Partnership in place in the U.S. at the moment and may be the most comprehensive and complex Partnership in the history of U.S. labor relations. Moreover, the parties have achieved a number of remarkable successes in the first five years of the Partnership, including:

1. Development and successful use of an innovative structure and interest-based process to negotiate a single five-year system-wide collective bargaining agreement. More than 400 management and union leaders were trained in joint problem solving and interest-based negotiations processes. They identified seven critical economic and organizational issues and divided into task forces to generate ideas and recommendations for consideration and approval by national and local officials and union members. The parties produced an agreement that increased wages and improved benefits, established a framework for sharing rewards from future performance improvements, and positioned them to implement the Partnership principles into on-going operations over the five-year term of the agreement. These negotiations not only stand as one of the signal accomplishments of the Partnership to date. They are also likely to be recorded by future historians as one of the most significant breakthrough negotiations in U.S. labor relations of our time.

2. Opening of the Baldwin Park Medical Center, a major new health care facility in Southern California, in record time under budget, with significant work process and hospital structure innovations created through the labor management Partnership efforts of hundreds of participants.
3. Use of an interest-based problem solving process to reach agreement on how to reorganize and dramatically improve the performance of an Optical Laboratory in Northern California that saved it from closing and which continues to produce measurable performance gains and job opportunities for Kaiser Permanente and its employees. The experience gained in this turnaround is especially helpful now. Effective August 2002 the parties planned and moved into a new facility in Northern California.
4. Implementation of approximately 50 projects in different work sites whose labor and management partners report significant bottom line savings and performance improvements.
5. Design and implementation of a joint Partnership governance structure and process, and training of hundreds of union and management leaders in Partnership principles and skills.
6. Agreement on performance targets and focused workplace-centered initiatives to fund performance-sharing plans for future years. In 2002 and 2003 the focus is on reducing workplace injuries and associated costs.

### **Challenges and Opportunities**

Significant challenges to the Partnership are, however, imminent. Our analysis leads us to conclude that the Partnership is once again at a critical juncture in its history and evolution. The parties are facing a set of challenges that could potentially have as significant an impact on the future of the Partnership as any of the pivotal events listed above. Discussions with Partnership leaders indicate that they are both aware of these issues and are putting in place efforts to address them. We summarize below what we see as the critical challenges along with opportunities for addressing them.

### **CEO Succession and Integration of the New Management Structure and Team**

Early indications are that the transition to a new CEO, George Halvorson, and senior management team of the Health Plan may be serving as a positive pivotal event that reinforces management commitment to the Partnership. Mr. Halvorson has identified the Labor Management Partnership as a key priority for all managers, has indicated he intends to devote his personal leadership to it, and has put in place a top management team with a history of commitment to, and experience with, the Partnership. One of the key issues facing the new management team is to reach consensus with their union partners on the scope



of shared decision-making that will govern the Partnership in the future. Is the original vision of a broad scope encompassing the full range of strategic decisions and operations as outlined in the “Pathways to Partnership” still appropriate, or is some modification of this vision needed? One way to address this issue would be to agree on what issues are to be subject to consensus decision-making, when management should consult with union leaders prior to making a decision, and what issues management and labor should each decide on their own before sharing with their counterparts. Specific initiatives, such as whether or how to implement the proposed shared services organizational model and the new Kaiser Permanente HealthConnect, provide opportunities for testing the consensus reached on these issues and for holding managers and union leaders accountable for implementing it.

### **Focusing on the Work Process: Using the Partnership to Enhance Patient Care**

As noted above, a number of positive examples of the use of the Partnership to achieve concrete operational improvements can be cited. However, the majority of front line physicians, middle and local level managers and union leaders, and rank and file employees are not yet directly involved in using the Partnership to change their work processes and relationships to improve the delivery of patient care. The priorities for the next two years—workplace safety/costs associated with workplace injuries, joint staffing, and issue (grievance) resolution—provide opportunities for now focusing the Partnership’s resources at the operational level on issues that directly affect how work is done and patient care is delivered. By doing so, more of the middle level and front line physicians, managers, union leaders, and employees can gain experience with the Partnership and use it to address the issues of direct and critical concern to them.

### **Deepening Middle Management and Physician Support for the Partnership**

Middle level and front line managers vary widely in both their exposure to and support of the Partnership. They work under heavy time pressures and expectations to meet stringent quality, service, cost, and other performance targets. Only recently has participation in and support for advancing the Partnership in their units become a significant factor in their performance assessment. Focusing more directly on improving work and clinical care processes should help build support from these groups. Learning from peers at different worksites about how use of the Partnership principles and processes helps achieve bottom line performance improvements is an effective way to build this support.

### **Deepening Union Capacity to Support the Partnership**

Only a small subset of union leaders have developed the skills and capacities needed to support the Partnership and engage in joint decision-making, and a significant number of union leaders are experiencing time pressures in meeting their other on-going responsibilities for representing their members in resolving

grievances and other day-to-day issues. Union leaders vary considerably in their views of how to balance involvement in the Partnership with their on-going traditional responsibilities for handling grievances and resolving local issues. A transition in key union leadership positions will also occur at some point in the not too distant future. Focusing on the priority issues chosen for the next two years should provide considerable opportunities for deepening union leadership experience with the Partnership and leadership capabilities. This is likely to require considerable expansion in training resources. It will also require considerable internal union discussion to reach a broader consensus on how to mix and balance joint decision-making with more traditional union responsibilities and leadership activities.

### **Measurement and Learning**

The parties have not yet agreed on the metrics that will be used to evaluate Partnership outcomes or put in place the analytic processes needed to track progress on these measures. Channels and forums for communicating and learning from successful use of Partnership principles are likewise not yet well developed. The metrics working group that has been formed and the proposal it is currently drafting provide an opportunity to gain the buy-in and broad-based consensus on the appropriate metrics to be used for evaluating specific Partnership projects and their overall impacts on Partnership goals, objectives, and priorities. The National Partnership Council is developing a new communications plan for sharing lessons learned across worksites. Implementing these measurements and learning plans and incorporating them into on-going management reviews and Partnership meetings will need to be given high priority to support the next phase of Partnership activities and initiatives.

### **Responding to On-Going, External Developments**

Other issues will also pose on-going challenges, such as the negotiations recently completed with the California Nurses Association, growing competitive pressures and health care cost increases, and workforce adjustments and redeployment processes. The experiences gained in working through the pivotal events that have arisen in the first five years of the Partnership provide a solid platform for addressing these and other challenges that are certain to arise as the Partnership moves into its next phase.

### **Concluding Comment**

In summary, the Partnership is at another critical juncture in its evolution. There is a sense of urgency in the minds of both labor and management leaders that is motivating them to address the challenges noted above. The parties have a number of clear opportunities to do so. Taking advantage of these opportunities should serve to advance the Partnership and broaden its base of support and impact on significant outcomes of concern to the organization and the workforce. If the experience of other Partnerships applies to this one, failure to address these challenges could put the future of the Partnership at risk and lead

to a reemergence of the highly adversarial relations that motivated Kaiser Permanente and its unions to create the Partnership in the first place. The parties have demonstrated their ability to address challenges such as these successfully over the course of the first five years of this Partnership. Past success positions them well to address current issues and other challenges that will arise in the future.

# INTRODUCTION AND OVERVIEW

**I**n October 1997, Kaiser Foundation Health Plan and Hospitals (henceforth Kaiser Permanente or KP) and the Permanente Medical Groups and 26 AFL-CIO local unions (representing 57,000 KP employees at the time) signed an historic agreement to enter into a comprehensive labor management Partnership. This is the largest and most ambitious labor management Partnership in the U.S. at present, and the most visible one to be established since the Partnership at Saturn Corporation of General Motors was put in place in the mid-1980s.

The parties have achieved remarkable successes in the first five years of the Partnership. They developed and used an innovative interest-based process to negotiate a single five-year system-wide national agreement that local unions incorporated into their local union agreements and ratified separately. They worked together to open Baldwin Park Medical Center, a major new health care facility in Southern California, in record time and under budget, with significant work process

innovations. They engaged in an interest-based problem solving process to reach agreement on how to reorganize and turn around the performance of the Optical Laboratory in Northern California that saved it from closing. They created a joint governance structure and process, and trained thousands of union and management leaders in Partnership principles and skills. Where front line physicians in clinics and hospitals have been involved with the Partnership, their active participation has helped the projects succeed. At least 50 projects in different work sites have been developed in which labor and management partners report significant bottom line savings and performance improvement. Current projects include the design and transition to a cutting-edge new laboratory in Portland, Oregon where KP employees have already achieved major quality and productivity improvements through Partnership efforts.

The parties have agreed on many focused workplace-centered initiatives and given unionized employees an

opportunity to earn additional income through participation in a Performance Sharing Program. Payouts are achieved by accomplishing key regional goals which are the same goals for the management plan. In 2002 and 2003, a major focus is on reducing workplace injuries. Kaiser Permanente has also experienced a major leadership transition, and realizing the benefits of Partnership is one of the new CEO's top objectives. Through these and other efforts, the parties have built support for the Partnership among a significant number of Kaiser Permanente managers, physicians, union leaders, and employees.

At the same time, significant challenges to the Partnership's continued success remain. Partnership principles are not yet well integrated into the standard operating procedures of Kaiser Permanente's management and workers. The nearly 80 interviews that inform this report document considerable differences in the vision that key leaders in labor and management organizations have for the Partnership and the degree to which Partnership should be integrated into their normal operations. Only a subset of union leaders has developed the skills and capacities needed to support the Partnership and to engage in joint decision-making with management. Some union leaders are concerned about their members' perceptions that they have grown too close to KP managers, or feel that a full integration into management decision-making is not desirable, while still wanting to have more voice in major decisions. A key local union of registered nurses in northern California remains opposed to and outside of the Partnership. A majority of the workforce responding to internal KP surveys reports relatively

little evidence of Partnership activities at their worksite, although this is changing. While key physician leaders and some frontline doctors express increasing commitment to working with union partners at both strategic and operational levels, most physicians are not yet engaged enough to see how the Partnership could help address their interests and concerns, while various logistical and professional considerations make it difficult for them to take the time necessary for more inclusive processes. Although a "metrics" committee has started this process, the parties still lack clear, agreed-upon indicators for tracking the contributions of the Partnership to bottom line operational performance outcomes of concern to key stakeholders.

Perhaps the key challenge facing the parties at this juncture is the need to recalibrate and focus Partnership activities to achieve concrete results on workplace priorities and outcomes. The parties have chosen reducing workplace injuries and associated costs as priority issues for the next two years. These and other issues directly related to the work process will interact with the introduction of the new KP HealthConnect system that is planned to roll out in KP facilities beginning in 2003. The U.S. health care system continues to experience severe competitive and cost pressures, especially in California, where premiums for state employee health plans just increased 25% in a single year.

Experience with Partnerships in other sectors of the economy suggests that taking note of these issues, and addressing them by using Partnership principles and processes, should serve to reinforce the Partnership and its

contributions to the outcomes of critical concern to the parties. At the same time, if these issues are not addressed effectively, the Partnership's further diffusion-- and indeed the survivability of the KP Partnership-- could be at significant risk.

This case study analyzes the evolution of the Labor Management Partnership (LMP) at Kaiser Permanente from its inception in 1997 to June 2002 and identifies a set of critical issues and challenges the parties face in moving forward. We present it to document and learn from experiences to date, and to serve as a tool for the parties to discuss and take action on the key challenges that lie ahead. The study, and a parallel case analysis of the interest-based bargaining process used to negotiate the 2000-2005 labor agreement, constitute the products of the first phase of our research on the Partnership. The next phase will track the effects on performance outcomes of Partnership initiatives underway in specific workplaces.

## Background and Methodology

Leaders of the Labor Management Partnership requested that we conduct this study to

- (1) Provide an independent review and public documentation of their experiences over the course of its first five years.
- (2) Identify challenges and opportunities facing the parties at this stage of the Partnership's evolution.

To accomplish these goals, we have interviewed approximately seventy management and labor representatives and employees, physicians, and

facilitators involved in the Partnership over the period of June 2001 to June 2002.<sup>1</sup> Interviewees were asked to describe their experiences with the Partnership to date, assess the Partnership against the expectations and goals set for it, and identify the issues facing the parties as the Partnership moves forward. All interviewees were assured that their views and comments would be confidential and that we would only attribute statements to them with their permission. In March 2002, a preliminary draft was circulated to those quoted. We conducted approximately ten additional interviews and made revisions to the draft based on feedback, factual corrections and clarifications offered to us. In addition, we have reviewed the large volume of documents the parties have collected to record their work and experience to date, and the results of internal "People Pulse" surveys completed in March 2000 and March 2002. We have also observed portions of two National Partnership Council meetings.

In presenting this case, we draw on evidence from a wide variety of prior labor management Partnerships we have studied and/or participated in

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<sup>1</sup> Research associate Noorein Inamdar, a PhD candidate at Harvard Business School and the Health Care Policy Program at Harvard University, conducted a number of the summer 2001 interviews and assisted in the metrics analysis. The research team chose interviewees based on recommendations from labor representatives, management representatives, physician managers, and facilitators. About 70% of the interviews were with California-based individuals. Sometimes we used a 'snowball sample' technique when one interviewee sent us to another. About 25 of the interviews were with individuals involved at some level in Baldwin Park and the Optical Lab, two projects we were directed to when we began the research. We re-interviewed top leaders more than once, and as time changed perspectives.

directly.<sup>2</sup> Throughout the report, we note key “pivotal events” in the evolution of the Partnership that previous studies have identified as generic challenges that labor-management change efforts tend to encounter. Each of these pivotal events has the potential for either reducing or reinforcing the likelihood of a Partnership continuing or succeeding.

### **Kaiser Permanente: Two Complex Health System Organizations**

Kaiser Permanente is America’s leading not-for-profit health maintenance organization, serving 8.6 million members in 9 states and the District of Columbia. Fully 80% of its operations are located in California, where the company program was founded. As an integrated delivery system, KP organizes, provides or coordinates members’ care across a full range of services including hospital and medical services, screening diagnostics, prevention and wellness care and pharmacy services. As a not-for-profit, KP is driven by its mission to meet the needs of its members and its social

obligation to provide benefits for the communities in which it operates.

In 1938, Henry Kaiser asked Sidney Garfield, M.D. to provide health care to the 6,500 workers engaged in building the Grand Coulee Dam and their families. Together they created the nation’s first pre-paid group health care practice and insurance program. Then, during World War II, Kaiser and Garfield, together with the unions representing blue-collar workers, formed an association to provide health care to Kaiser’s expanding steel and shipbuilding businesses in California, Oregon and Washington. Shortly after the war, the plan opened to the general public and gradually expanded; in large part by adding other union health plans to its customer (they call their customers “members”) base. Advance payment of union dues helped provide Kaiser with money to expand into southern California.

In the 1950’s the organization was re-named Kaiser Permanente and developed into a Partnership between two organizations: (1) Kaiser Foundation Health Plan and Hospitals, and (2) The Permanente Medical Groups. The latter (PMGs) are composed of more than 11,000 physicians and other health care providers, while the former is made up of the health maintenance organization (HMO) insurance plan and the 29 medical centers and many other health care facilities owned by Kaiser. The various Permanente Medical Groups operate as for-profit corporations or limited partnerships, contracting services solely to Kaiser Foundation Health Plans and Hospitals; at the same time, Kaiser Foundation Health Plan and Hospitals retains its not-for-profit status. Not surprisingly given its origins, workers employed by the

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<sup>2</sup> For reports on a number of prior partnerships conducted by members of our research group, see, Joel Cutcher-Gershenfeld, “Tracing a Transformation in Industrial Relations: The Case of Xerox and the Amalgamated Clothing and Textile Workers Union,” Washington, D.C., U.S. Department of Labor, 1988; Thomas Kochan and Joel Cutcher-Gershenfeld, “Diffusing and Sustaining Innovations in Industrial Relations,” Washington, D.C. U.S. Department of Labor, 1988; Thomas Kochan and Susan C. Eaton, 1996, “New Ideas on Resolving Workplace Disputes,” *Negotiation Journal*. Saul Rubinstein and Thomas Kochan, 2001 *Learning from Saturn*, Ithaca, NY: Cornell University Press; Robert B. McKersie “Lessons from Partnerships,” *Transfer*, 2001, Susan C. Eaton, Saul Rubinstein, and Robert B. McKersie, “Building and Sustaining Labor-Management Partnerships,” unpublished paper, August 2002.

partnership that we call Kaiser Permanente (KP) unionized shortly after the non-profit organization was created, and long before non-profit hospitals were required to recognize unions under federal labor laws. The union membership and Kaiser Permanente grew together, and unions now represent most eligible workforce members.

Today KP employs approximately 130,000 workers, of whom 79,000 are represented in the Labor Management Partnership by one of eight different international unions and one independent union. Since KP's operations are highly decentralized, so too has been collective bargaining for most of Kaiser Permanente's history. Traditionally, bargaining has taken place separately with more than 50 different local bargaining units, each of which was governed by a separate contract with different expiration dates. There are several categories of workers—exempt; non-exempt; non-union; union represented; and members of Partnership unions. This is relevant since organizing the unorganized union-eligible workers has been a major goal of the union coalition and something that is made easier under the LMP agreement.

### **Motivating Forces and Internal Debates**

Kaiser Permanente was founded together with labor. The organization's leaders also worked to develop positive relationships with the unions representing its workforce. While labor management relations have had their ups and downs over the years, they have been mostly positive for most of KP's 50-year history. One reason for this is that until the 1980s, KP could use

some cost-plus pricing and thereby pass on the costs of improvements in its labor contracts to its customers. Unions also found Kaiser Permanente attractive as a service provider for their members and negotiated KP options into many contracts. It also was one of the lowest-cost health care providers until the 1980's, and as an innovative HMO it focused on preventive services at reasonable cost that served working families especially well.

In the late 1980's and early 1990's, KP began experiencing severe competitive challenges, particularly from for-profit health care providers aggressively seeking to increase their market share. KP also decided to pursue an expansion strategy around the country, including in predominantly non-union areas such as Atlanta and North Carolina. KP posted severe financial losses, totaling \$900 million altogether, in the years 1995-97, which was a major shock to a company that had never lost money to any significant degree. The organization took a serious patient care focus, but it also had major capacity issues. To bring in new members and new revenues, it lowered prices. But because it had always targeted and drawn on a very price-sensitive part of the health care market, the lowered prices brought in more members than expected. As a result, KP lost money because it did not have the internal capacity, especially in the number of hospital beds, to treat its own enrolled patients. In this situation, doctors would refer patients to non-KP hospitals, and this was an extremely expensive option since KP had to pay full price for those hospital treatments and had no control over any of the expenses. Thus internal capacity had to be carefully monitored and expanded when necessary and this is hard to do



(new hospitals cannot be built from scratch without several years' advance notice and complex regulatory approval).

Responding to these new competitive pressures, KP management implemented a new, tougher labor relations strategy that produced a series of layoffs, strikes, collective bargaining concessions, perceived 'de-skilling,' and an increasingly demoralized workforce. "This is not the Kaiser we came to work for" was a comment often heard from frontline workers.

By 1995, a crisis was building. The largest single national union at KP, the Service Employees International Union (SEIU), began to convene its local unions with KP union members to discuss strategy. "This was contrary to how we wanted to build relationships and build the industry," recalled Margaret Peisert, then an SEIU researcher and now Assistant Director of the Coalition of Kaiser Permanente Unions (CKPU). SEIU then turned to the Industrial Union Department (IUD) at the AFL-CIO and asked its staff to call a meeting of all the unions representing workers at KP. The SEIU was joined in this request by KP nurses represented by the American Federation of Teachers (AFT). The IUD had many years of experience in coordinating bargaining efforts, and so Peter diCicco, then President of the IUD, welcomed setting up a meeting to address the critical problems at Kaiser.

Below, diCicco describes how they got started:

*We took our normal approach. We called an initial meeting of all principal unions. More than 100 people attended. We knew from experience that we had to get all the unions on board with a clear*

*strategy for how to deal with Kaiser. It became evident, given the negative attitude of the public toward strikes in health care, we had to consider other options-- and so we began looking at other means to achieve bargaining strength—corporate campaigns<sup>3</sup> and such. I went to the international unions for a supplemental budget to fund the corporate campaign. They accepted the supplemental budget and we staffed up and started the corporate campaign.*

*But it became clear to us if we proceeded with the campaign, we would lose control of all this. The government might step in and we would all lose. So I went to the international union presidents and told them these guys [Kaiser] are not the worst of employers we deal with, and we might do permanent damage to them and to our 75,000 union members if we mount an all-out corporate campaign or use the information we amassed for short-term advantage or leverage. Was there an alternative?*

One union activist, Kathy Schmidt (who was then President of the Oregon Federation of Nurses and Health Professionals, American Federation of Teachers) remembers those days, after concession bargaining for thousands of union members had reduced or frozen wage and benefit packages.

*We formed a coalition to keep from getting killed in bargaining. We didn't even know the P-word [Partnership]. We came together for bargaining expertise. They (management) brought in these McKinsey people, who were*

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<sup>3</sup> A corporate campaign is a coordinated research and public disclosure initiative undertaken by unions to bring public attention to a company in an effort to change the company's labor relations practices.

*going to close all the hospitals, seven in California alone, take out the integrated care system, and maintain their competitive position by lowering their labor costs. A round of bargaining started in 1994-5 that was just brutal—we intercepted some business plans and faxes and emails – they were just going to kill us. After that round of bargaining, we said ‘never again’, and we started building a corporate campaign capacity to bring them to their knees in bargaining. Then we realized, here is the most unionized system in the country, why don’t we try to help them? We learned more about trying to have a Partnership.*

Peter diCicco continues,

*My background was in Lynn [Massachusetts where Peter led the International Union of Electrical Employees local representing employees at General Electric] where we had started a job enrichment process. And the AFL-CIO had developed a document outlining principles for labor management Partnerships.<sup>4</sup> So we had some options. Perhaps we could use our bargaining strength at the table or offer the option of a Partnership approach with Kaiser.*

*We had John Sweeney, who at that time was President of the SEIU [later to become President of the AFL-CIO], make an overture to David Lawrence, [then] KP’s CEO and that started the process. It took Kaiser six months to consider the idea. The Board of Directors discussed it at length. Fortunately, the former chair of Northwest Natural Gas was on the board and he had a very positive*

*experience with a labor management Partnership in his company. After consulting with him and other board members, Lawrence came back to Sweeney and said, “Let’s explore this idea.”*

*We asked John Calhoun Wells, Director of the Federal Mediation and Conciliation Service (FMCS) to convene a meeting of top executives and labor leaders in Dallas. We went to that meeting ready to blast KP for its behavior. At the top of our list was patient care—that’s where the frustration was the greatest among our members. But Lawrence started with a statement that disarmed us. He said all the things we were prepared to say. It was clear that there was almost total alignment of objectives. So from that point it was just a matter of walking through the steps.*

David Lawrence, M.D., former CEO of the Kaiser Foundation Health Plans and Hospitals, describes the inception of the Partnership as follows:

*At some point Al Bolden [Vice President of National Labor Relations at KP] and Pete talked about the need to get together and try something different. And I was willing to try anything at that point because it was clear that the path we were on...was a dead end. We were going to be facing labor strife in every corner of our organization. We had 54 labor contracts, 36 unions, and if they go south on us, similar to what happened -- at the same time we were in a fair amount of conflict between the Medical Groups and the Health Plan -- what I saw was an organization that was starting to balkanize in very serious ways. A lot of this was being driven by*

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<sup>4</sup> The New American Workplace: A Labor Perspective. Washington, D.C.: AFL-CIO, 1994.

*external things, a lot of it was being driven by changes we were trying to make in the organizations at a strategic level.*

*I agreed ... that we would meet with labor representatives privately at Dallas-Ft. Worth airport. It was almost a make-or-break meeting. What I remember thinking about at that meeting was: We've got nothing to lose by being forthcoming about what I believed needed to happen in terms of the relationships...[and] about the kind of collaboration that I think is required to deliver modern medical care in all of its complexity. We had nothing to lose in acknowledging the fact that there are no answers to these things; they grow out of the collective effort of teams of people who are working on specific areas of medical care delivery in terms of how you best organize.*

*So I said these things. Peter said I took away all of his thunder because he was prepared to say all of those things. And it turned out that there was almost a revelatory session....*

One of the first things the parties did after agreeing to pursue more collaborative strategies was to look for a consulting firm with significant experience in facilitating labor management Partnerships. After interviewing a number of candidates, they chose the Washington D.C.-based firm Restructuring Associates, Incorporated (RAI), founded by Tom Schneider. Facilitator and consultant John Stepp led RAI's efforts. Stepp brought a wide range of experiences to the process, as a former mediator from the FMCS and a former Deputy under Secretary of Labor and head of the Department's Bureau of Labor

Management Relations and Cooperative Programs. He is a national expert on how to design and sustain labor management Partnerships. Schneider and Stepp gradually brought in a number of other facilitation experts to the project. And FMCS made up to twenty commissioners available to facilitate the process of bargaining.

"Walking through the steps" to produce a real Partnership agreement was actually an intensive negotiation and problem-solving process that took most of 1996 and into 1997, led by senior KP executives and union leaders, with significant assistance from RAI's John Stepp and Tom Schneider. The toughest issues involved employment security, union security, and the scope of shared decision-making. An approach to shared decision-making was proposed by RAI using a continuum ranging from at one end, unilateral decision-making with management informing union leaders of actions to be taken, to full participation and consensus decision-making on the other end. Union security was addressed in an agreement providing for management neutrality and card check procedures for any future organizing of nurses and other bargaining unit staff (but not for physicians). Kaiser agreed to recognize requests for union representation with a majority showing of support but without an election in new locations. This was significant because at that time, 10,000 union-eligible employees were not yet organized into unions.

Employment security proved to be the toughest issue. The language finally agreed to by the parties stated that one Partnership Agreement goal was to "provide Kaiser Permanente employees with the maximum possible employment and income security

within Kaiser Permanente and/or the health care field." This was later to require additional clarification, but it was an essential element of the initial agreement, especially given the memory of very recent layoffs during periods of financial stress. "People felt it was fundamental," says Peisert. "You couldn't ask people to step up to the plate, change the way they were doing things, get involved in joint decision making, redesigning work, and figuring out new ways of delivering services, or finding efficiencies, if they were going to be putting themselves or a coworker out of a job."

Once the labor and management leaders agreed on the key provisions of the Partnership, it was submitted to a vote of the membership of the 26 unions. Before this vote, however, an intensive process of education of the frontline workers and union members took place. Most union members had never heard of a labor management Partnership, nor did they have any idea how it would affect their interests. The unions held a national teleconference to brief local and regional union leaders, and produced videos describing the Partnership that featured AFL-CIO President John Sweeney describing his vision for what a Partnership of this size and scope could mean for the future of labor relations in America and for the labor movement.

The Partnership was approved by a vast majority of the local union members voting, with high turnout. One major union choosing not to join the Partnership was the California Nurses Association (CNA), representing approximately 8,000 nurses; the leaders of CNA chose to withdraw from discussions before the Partnership was negotiated in final form, in part because of ongoing disputes with Kaiser

Permanente. The Guild for Professional Pharmacists, representing KP pharmacists in all the West Coast facilities, also chose not to join at that time. Hawaii's KP region had a pre-existing partnership program of its own that included labor and management and so did not join formally.<sup>5</sup>

In addition, one nurses' unit in Oregon that initially did not join, has since voted to do so. Overall, of the approximately 65,000 unionized employees, 57,000 would initially come under the Partnership, and this has now increased to 79,000.

**Figure 1** on the following page lists the key provisions of the agreement ratified by the parties in June 1997. These provisions illustrate the breadth and extent of the 1997 Partnership Agreement. In 2002, senior union and management leaders agreed to a seventh LMP goal: Consult on public policy issues and jointly advocate when possible and appropriate.

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<sup>5</sup> See the "Understanding Kaiser Permanente: Hawaii's Success" report issued by KP's internal Consulting Services unit that documents some of the positive aspects of the partnership between management, physicians, and employees in Hawaii. December 28, 1999.

**Figure 1**  
**Kaiser Permanente National Labor Management Partnership Agreement (Excerpts)**

<b>PURPOSE</b>
<ul style="list-style-type: none"> <li>• Improve the quality of health care for Kaiser Permanente members and the communities we serve.</li> <li>• Assist Kaiser Permanente in achieving and maintaining market leading competitive performance.</li> <li>• Make Kaiser Permanente a better place to work.</li> <li>• Expand Kaiser Permanente’s members in current and new markets, including designation as a provider of choice for all labor organizations in the areas we serve.</li> <li>• Provide Kaiser Permanente employees with the maximum possible employment and income security within Kaiser Permanente and/or the health care field.</li> <li>• Involve employees and their unions in decisions.</li> </ul>
<b>PROCESS AND STRUCTURE</b>
<ul style="list-style-type: none"> <li>• Senior Partnership Committee: Executive level of KP Executives and Union Leaders to establish targets, goals, timelines and to discuss strategic issues, and to oversee implementation and review of the process.</li> <li>• The parties recognize and agree to hold proprietary information in strict confidence and agree information obtained in the course of the Partnership will not be used to the detriment of the other partner.</li> <li>• The parties will jointly select a third party consultant to assist the Partnership.</li> <li>• Each business unit participating will establish a Partnership Steering Committee with equal numbers of members from the unions and the company.</li> <li>• Kaiser Permanente will bear the costs of administering the Partnership. Union officials who are not Kaiser Permanente employees will be responsible for their own costs.</li> </ul>
<b>DECISION MAKING AND SCOPE</b>
<ul style="list-style-type: none"> <li>• Decision-making will vary from situation to situation but should be governed by two criteria: (1) The degree to which the parties’ constituent or institutional interests are likely to be affected by the decisions; (2) the level of expertise or added value the parties can bring to bear on the decision to be made.</li> <li>• If either party’s vital interests are likely to be affected by the decision, consensus should be used. If constituent or institutional interests are even marginally affected, consultation should precede a final decision.</li> <li>• If one party has little, if any, interest in the outcome, and no particular expertise on an issue to be decided, informing is adequate.</li> <li>• In the absence of consensus, mandatory bargaining subjects will be resolved in accordance with contractual and legal rights. On non-mandatory and non-contractual subjects, management reserves the sole responsibility and right for the final decision.</li> <li>• The scope of the Partnership should be broad and should include: strategic initiatives; quality; member and employee satisfaction; business planning; and business unit employment issues.</li> </ul>
<b>EMPLOYMENT AND UNION SECURITY</b>
<ul style="list-style-type: none"> <li>• The parties acknowledge a mutual obligation and intention to maximize employment security for Kaiser Permanente employees. We recognize that there could be circumstances when such a commitment cannot be achieved. In such cases, the Partnership will make use of attrition, growth of the business, aggressive job matching, short-term training efforts and other mechanisms agreed upon by the Partnership participants. There will be no loss of employment to any employee because of participation in a Partnership program or worksite.</li> <li>• The parties believe that Kaiser Permanente employees should exercise free choice and decide for themselves whether or not they wish to be represented by a labor organization. Where a signatory union becomes involved in organizing Kaiser Permanente employees, the employer will maintain a strictly neutral position.</li> </ul>
<b>MARKETING COOPERATION</b>
<ul style="list-style-type: none"> <li>• All parties will make their best efforts, as opportunities arise, to market Kaiser Permanente to new groups and individuals and to increase Kaiser Permanente’s penetration in existing groups.</li> </ul>

**Figure 2: Common Goals of the 1997 LMP Agreement**

<b>Kaiser Permanente and the undersigned labor organizations agree to establish a Partnership in pursuit of our common goals:</b>
• Improve quality of health care for KP members and communities we serve;
• Assist KP in achieving and maintaining market leading competitive performance;
• Make KP a better place to work
• Expand KP membership in current and new markets, including designation as a provider of choice for all labor organizations in the areas we serve
• Provide KP employees with the maximum possible employment and income security within KP and/or the healthcare field
• Involve employees and their unions in decisions
• Union and Management Leaders agreed to a seventh LMP goal: consult on public policy issues and jointly advocate when possible and appropriate *

**\* The seventh goal was added in 2002**

The objectives outlined in Figure 2 above address the key bottom-line concerns for improving the quality of health care, expanding KP membership and market share, and improving KP's performance, as well as key employee and union objectives of providing employment and income security, making KP a better place to work, and involving employees and union leaders in decision-making.

The original Labor Management Partnership (LMP) structure is depicted in **Figure 3** on the next page. The top two dotted boxes represent the two separate coordinating and oversight bodies for KP and the unions: the Kaiser Permanente Partnership Group (KPPG) and the Coalition of Kaiser Permanente Unions (CKPU), respectively. Peter diCicco chairs the CKPU. Twenty-six local unions participate in this body. The KPPG was created after considerable internal debate to coordinate the work of the Hospital and Health Plan and the

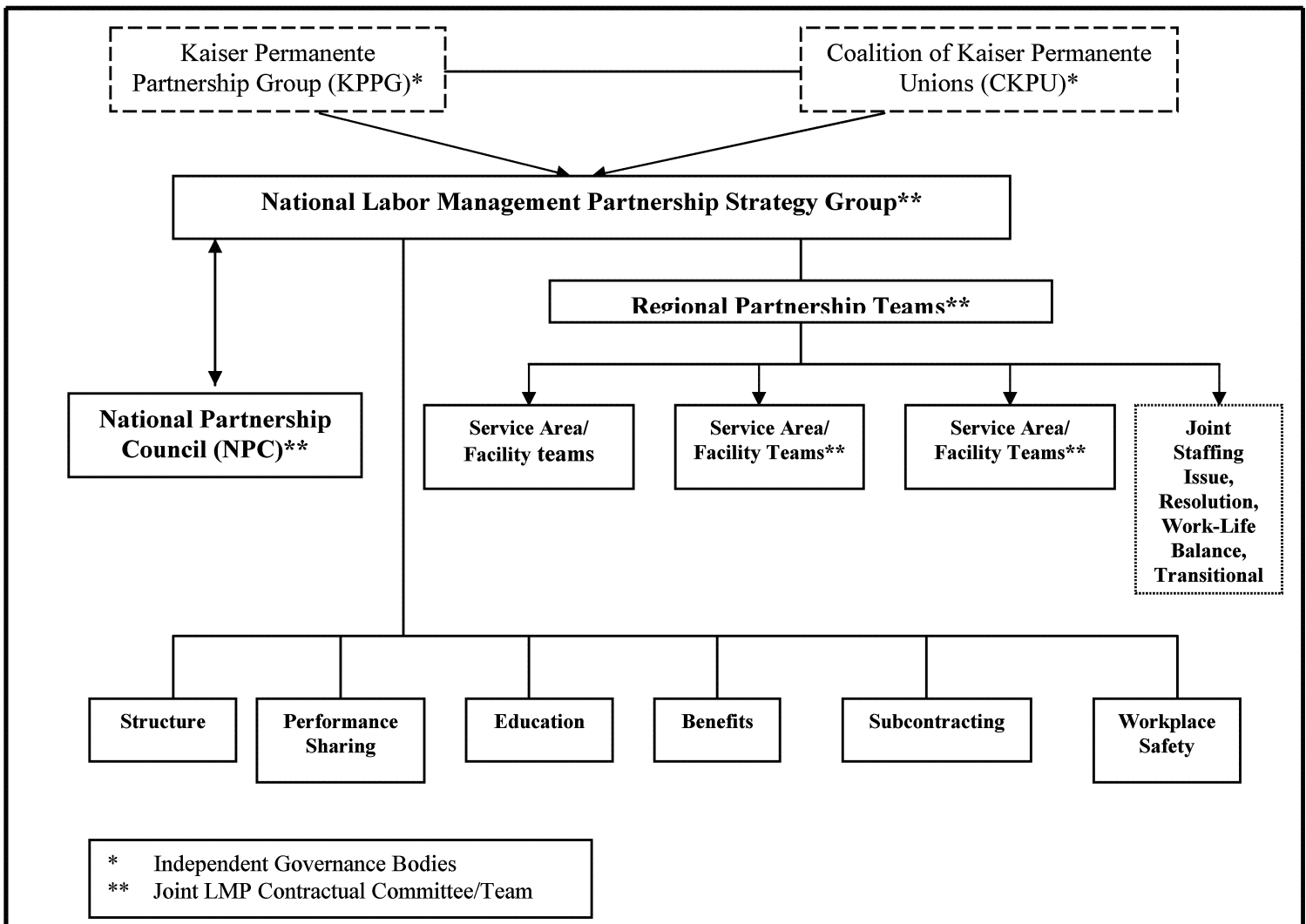
Permanente sides of KP. Francis J. Crosson, M.D. is the co-chair of KPPG, appointed by the medical groups. Dale Crandall, then the President of KFHP/H served as the other co-chair until his retirement in 2002. Leslie Margolin, then the Senior Vice President (SVP) for Workforce Development, also served as a member of the KPPG. This group now meets once or twice a month. While no union representatives are formally part of the KPPG, CKPU leader Peter diCicco is now invited to attend these meetings to participate as an observer. The KPPG membership and its role is now evolving as part of the broader restructuring of management personnel and responsibilities announced in June 2002 by the new KFHP CEO and Chairman of the Board, Mr. George Halvorson.

The top governing body of the LMP is the Strategy Group, consisting of twelve union leaders and senior operating managers and physicians, which meets eight times a year. Until

early 2002, the Strategy Group was co-chaired by Peter diCicco and Leslie Margolin. A staff organization, the Office of Labor Management Partnership (OLMP) reports to both co-chairs. The National Partnership Council (NPC: see Figure 3) meets four times a year and brings together approximately fifty union and management officials to share reports

and to enhance coordination across the many parts of the KP organization. The Strategy Group is a key working body of the Partnership, and the National Partnership Council members are presently working to identify how they can provide more support to operational Partnerships at the local level, as well as involve more middle-level labor and management leaders.

**Figure 3: Joint LMP Contractual Committees**



## Pathways to Partnership

To direct and support the implementation of the original six goals, the parties developed a “Pathways to Partnership” five-phase plan. The document highlights seven key elements and describes in detail the following five phases of implementation for each: traditional, foundation building, transition phase I, transition phase II and vision. The seven key elements are: *performance targets and measures, union’s role and management’s*

*role in decision-making, employees’ role in the workplace and decision-making, labor relations, compensation, employment security and quality of healthcare.*

**Figure 4** below provides a summary of descriptions and activities under each of the five phases. The “Pathways to Partnership” represents a major effort to develop a labor management implementation strategy with the understanding that achieving organizational change takes a staged approach over a number of years.

**Figure 4: Five Phases of Pathways to Partnership**

Traditional	Foundation Building	Transitional I and II	Vision
<ul style="list-style-type: none"> <li>• Adversarial</li> <li>• Rule Based</li> <li>• Problem Settled Not Solved</li> <li>• Decision-Making Seldom Shared</li> </ul>	<ul style="list-style-type: none"> <li>• Education &amp; Training</li> <li>• Issue Resolution</li> <li>• Establish Teams</li> <li>• Involve Employees and Physicians in Decisions</li> </ul>	<ul style="list-style-type: none"> <li>• Input into Decision- Making</li> <li>• Trained in Conflict Resolution</li> <li>• Collective Bargaining</li> <li>• Business Education</li> </ul>	<ul style="list-style-type: none"> <li>• All Employees and Physicians with full Understanding of the Business</li> <li>• Union Leadership Integrated into Decision-Making</li> <li>• Interest-Based Bargaining</li> <li>• Accountable Teams</li> <li>• Consensus Decision-Making</li> </ul>

## Employment Security: A Critical Issue

As noted above, the general language on employment security required clarification. In 1999 issues had arisen regarding the redeployment of bargaining unit staff. The National Partnership Council and other union and management leaders met to discuss this. Here’s what one top management negotiator had to say about discussions within management meetings:

*That [employment security] was another cornerstone [of the Partnership]. First, I persuaded them that they had confused employment security with job security. They thought employment security meant no flexibility for redesign and no flexibility for performance. We garnered a lot more support when I persuaded them that wasn’t the case. Then the second worry was, what if something horrible happened, we can’t have our hands tied, if there’s an earthquake or a flood or a hospital closing, we can’t guarantee everyone jobs. And our labor partners weren’t talking about that, something*



*horrible. So you see in the language, there is some exception for huge horrible events, and it is still defined by management. So that solved that problem. Third, they said, we can't afford it. But I asked the management people to figure out... how many vacancies we have. Typically, we always have an 8 to 10% vacancy rate. So it's not a question of having too many people. We can be creative in retraining and redeploying people... That was critical. The leaders and managers just needed time to understand.*

Finally, the parties crafted a separate agreement on employment security dated October 20, 1999 that clarified their understandings and laid the groundwork for ongoing Partnership. The clarification covers five pages and lays out in some detail the commitment to “re-deploy, not lay-off, employees who are displaced.” Both parties would need to behave differently than in the past, as with so much of the Labor Management Partnership—with unions permitting increased flexibility and management engaging in proactive problem solving and planning ahead for long-term workforce needs.

# NEGOTIATING THE 2000 NATIONAL AGREEMENT

**W**hen the Partnership Agreement was signed, the parties made a decision to keep Partnership activities separate from collective bargaining. Union leaders felt that to do otherwise would risk losing local union support for Partnership activities. This has been a standard, widely accepted tenet for starting joint, labor-management efforts. It is common to begin with a principle or written rule that essentially says, "none of the changes that will be implemented will infringe on or modify terms and conditions of existing collective bargaining agreements." This helps gain support of both management and labor leaders who are skeptical of joint efforts and fear those efforts will erode hard-won gains or managerial control. Yet, as RAI consultants pointed out, the dilemma that all Partnerships face at some point is that if they want to tackle the critical issues facing the business and the workforce, they have to find an appropriate and effective way of integrating their joint efforts with the collective bargaining process and the provisions of their labor agreements.

This is often the first test of a Partnership; those who can do this in a way that gains the support of elected union officials with bargaining responsibilities and key managers who control bargaining strategy and decision-making within management, can move joint efforts on to the next phase in the change process. Those who cannot overcome this hurdle often fail at this point because they cannot get at the key issues facing the parties.

## **The Northwest Region Strike**

It did not take long for the KP LMP to experience a pivotal event that raised this question. "We still had 40 or so separate contracts, there was one coming up every other week, and they were all on a different cycle," said Peisert. Shortly after the Partnership Agreement was signed in 1997, a strike in Portland, Oregon forced the parties to address this issue. It showed how vulnerable the Partnership could be to local conflicts and convinced the Partnership leaders that a new approach was needed. Peter diCicco describes this event:

*One critical point was after the Partnership agreement was signed we had a strike by the SEIU local in Portland, Oregon. The nurses (members of AFT) then started a supportive sympathy effort and some of them participated in a sit-down activity. When 10-12 nurses honored the picket lines, management threatened to fire them. If management followed through, this would have been an all out war. I ended up working hand in hand with Dick Barnaby [then President of Kaiser Foundation Health Plans and Hospitals] to avoid this. I personally went up to Portland to help the local negotiate a settlement.*

While this pivotal event produced recognition that a new approach to bargaining was needed, the question was: How could this be done? Since the various local unions had gained experience working together in negotiating the initial Partnership agreement, their inclination was to propose that everyone negotiate together and create a single national agreement with supplements that dealt with specific local issues. (Such agreements are common, for instance, in the automobile industry.) But KP officials were strongly opposed to this, fearing that a single common contract deadline would greatly increase union bargaining power by threatening a system-wide work stoppage. The question, therefore, was: Could some new approach be developed that would address the need for more coordination that either avoided a common expiration date for all contracts or addressed management's concerns in other ways?

## **Designing a Framework and Process for Negotiations**

A joint task force was created to explore this question. The initial idea favored by the union coalition and proposed by the task force was to consolidate bargaining and negotiate a single national master agreement, but without a common expiration date. The unions knew that a common expiration date was a "show stopper" for KP. When this idea was first proposed by the joint group to the Kaiser Permanente Partnership Group (KPPG) in 1999, it was vehemently rejected. At least one physician leader felt the basic 'groundwork' had not been laid with top leaders. Others said the rejection was primarily out of concern that units in labor market areas outside of California would be unable to pay higher "national" rates. But some union leaders felt that their management counterparts on the joint task force had 'sandbagged' them. Also, key management Labor Relations and Partnership leaders Al Bolden and Gary Fernandez retired at about this time. "Kaiser had to really grapple with, 'Is this what we want?'" said Judith Saunders, Director of National Labor Relations for KP.

The rejection of this proposal created a crisis that could easily have led to the demise of the Partnership. Francis J. Crosson, M.D. took the lead in re-starting the discussion at KPPG. Then-CEO David Lawrence urged the KPPG to continue working to resolve the differences so that the Partnership would not fail. Senior VP Leslie Margolin played a key role in continuing discussions. William Hobgood, then Senior Vice President of People at United Airlines, was invited to meet with the KPPG because of his extensive experience with a variety of

labor management relationships and structures. He was asked to discuss the advantages and disadvantages of these different arrangements. Facilitator John Stepp then worked with Crosson, Margolin, and other KPPG leaders, as well as with the union leadership, to fashion an alternative approach with various “gates” that the parties would move through before negotiating a national agreement. Either side could exit the process as it passed through these gates if they felt it was not moving in a constructive fashion.

In view of the primary reason for the initial rejection of the national contract idea, an important “gate” was agreement in principle that local labor market rates would continue to govern. Another critical step involved training of potential participants, nearly 400 in all, in national and local negotiations in the concepts and skills of Interest-Based Negotiations (IBN). Another key “gate” was that either party could pull out of the process at any point. (As it turned out, neither party found it necessary to exercise this option.) The task force eventually came back with a revised proposal that called for extensive use of IBN problem-solving principles and the necessary training to prepare the parties for this very complicated process, a single integrated national negotiation that also allowed local agreements to retain their respective deadlines (thereby addressing one of management’s fears of a common expiration date), and a series of decentralized task forces that would focus on particular issues. It would be a single, integrated national negotiation but would not have a specific deadline for agreement.

The KPPG and the leaders of the union coalition approved this revised proposal in February 2000. The actual

negotiations, structure and process are described in detail in a separate case study (see McKersie, Eaton, and Kochan 2002). For our purposes here, it is sufficient to say that these negotiations will be recorded as the largest and most innovative and successful experiment with interest-based negotiations processes conducted to date in U.S. labor management relations. They involved nearly 400 union and management representatives and more than twenty neutral facilitators. The negotiations included eight international unions with 26 locals.

Seven decentralized bargaining task groups (BTGs) were established to address (1) wages, (2) benefits, (3) work-life balance, (4) performance and workforce development, (5) quality and service, (6) employee health and safety, and (7) work organization and innovation. Each group engaged in an interest-based process of joint study, problem-solving, and negotiations. These task groups reported their recommendations to a joint centralized Common Issues Committee (CIC) co-chaired by diCicco and Margolin. Facilitators from RAI and FMCS assisted each of the groups. In addition to negotiating a national agreement, new local agreements would be bargained, even though most were approaching their expiration dates. The CIC would sort through those issues and recommendations that needed to be forwarded to the local tables and those that applied uniformly across the system and therefore needed to be negotiated centrally by the CIC. According to Judith Saunders, the idea was not to have proposals and counter-proposals:

*We did not want to approach these negotiations in a traditional manner,*

*where each side submits 100 proposals directing the discussion to singular solutions. Alternatively, we jointly identified and agreed to broad subject matters and structured joint teams around each subject. The teams were charged with identifying the issues related to their topic and, in an interest-based manner, recommending solutions that met the interests of both sides.*

Most of the important issues (except for the negotiations over wages) were tackled within the seven BTGs. Consider the experience of one sub-committee within the BTG that addressed the subject of performance and workforce development. This group consisted of approximately twelve people and included a person from Operations at one of the hospitals, a vice president from one of the nursing unions, and other management and union leaders with direct experience with and responsibility for the issues within this group's mandate. The schedule involved meeting for long hours for three consecutive days every other week. During the interlude, members of the committee reflected on what had happened, consulted with constituents, and accomplished behind-the-scenes liaison work that was necessary. Guidelines from the CIC urged the BTGs not to propose specific language but to produce guidelines and statements embodying concepts and principles.

The BTGs were each staffed with two facilitators, one from RAI and the other from FMCS. They intervened, especially when the parties got stuck, by asking them to go back to the fundamentals of IBN: identify interests and generate new options. The facilitators also managed the lists from the flip charts, prepared notes, and,

during the intervening night after each day's session, produced a summary to help launch the next morning's session.

**Figure 5** lists the chronology of key steps in the negotiation process. Between May and July 2000, the parties worked on these issues within their sub-groups. They met for several days at a time and then disbanded to consult constituents. When a group reached consensus, it presented its recommendations to the CIC. The national committee, in turn, passed on these recommendations to local unit bargaining committees for them to adapt and fine-tune the recommendations to fit specific local conditions. Members of the CIC were assigned to each BTG. Their role was intended to be as follows:

*They are not to be co-chairs; they will play a leadership role and model the IBN principles and behavior; they will help keep the BTG on task and on target; and they will serve as the eyes and ears of the CIC.*

**Figure 5**  
**Chronology of the Negotiations Process**

<b>March 2000</b>	Management and unions separately solicited proposed issues from their constituencies.
<b>April 2000</b>	Local unions and 300-member Union Bargaining Council approved process; Common Issues Committee members went through training; Management and unions separately, and jointly through the Common Issues Committee, determined there were sufficient common issues with potential for agreement.
<b>Early May 2000</b>	Common Issues Committee chartered Bargaining Task Groups.
<b>May-June 2000</b>	Bargaining Task Groups underwent training, met to identify issues, mutual and separate interests, develop options and recommendations.
<b>Early July 2000</b>	Bargaining Task Groups presented options and recommendations to the Common Issues Committee; Common Issues Committee determined there were sufficient common issues with potential for agreement, triggering additional local bargaining by all 26 local unions. The local bargaining tables were all trained in IBPS/CDM.
<b>Mid-July-Early September 2000</b>	Common Issues Committee determined guidelines by which issues were to be negotiated nationally or locally; Common Issues Committee bargained national issues while local unions and local management negotiated local issues.
<b>Late August 2000</b>	Framework for a national agreement was tentatively agreed to by the Common Issues Committee, approved by KP's senior management, and endorsed by the 300-member Union Bargaining Council; additional guidelines for local bargaining were released to local unions and local management.
<b>September-October 2000</b>	Tentative national agreement and tentative local agreements submitted to membership of the 26 local unions for ratification; agreement ratified by 92% majority.

By early July 2000, the BTG's had finished their work and were ready to report back to the CIC. Approximately 300 people from the BTG's assembled in one room. Eventually all members of KPPG participated in parts of the meeting. Each BTG presented its work. The scene was incredibly energizing, according to one individual; everyone came away from the session on a real "high."

Initially the CIC, in adopting specific rules for the timetable of the process, had proposed that negotiations

should be concluded by September 1 with the package then recommended to the various memberships for ratification, and local bargaining needed to mesh with this schedule. Issues had to be sent down to local bargaining teams. A big task was separating local bargaining versus national bargaining issues. Dealing with this took time. The economics and the wage subjects took longer and some subjects required more data and research. As a result, the parties needed several weeks beyond

the September 1 target to finalize a tentative agreement.

The final stages of the process were characterized by a number of twists and turns (not revealed by the chronology). With the September 1 target in mind, the CIC in mid-August entered into what turned out to be a nine-day marathon session to resolve all of the outstanding issues, if only in principle so that local negotiations could proceed to the finish line. As September 1 approached and it became clear that the task of codifying the results of the marathon session was not finished, several of the large unions “pulled the plug” and said that they would not proceed with their local negotiations until they received appropriate guidance from the CIC (especially with respect to the resolution of money items).

Consequently, the CIC found it necessary to reconvene in early September. Whereas the makeup of the CIC for the marathon session in August had numbered around 40, the participants in early September numbered about ten. This “end game” phase resembled traditional bargaining in some respects with some representatives, as one representative put it, “shaking the trees one more time.” The pace intensified with 20-hour a day sessions. After six of these long sessions, agreement was reached on all but a few agenda items, thereby providing the guidance that several local unions needed. While there was some fine-tuning of economic items at the local level, when the final package was sent back to the locals they had to accept or reject the full package, not pieces of it or modifications of it. Completing the task at the local level required another week; thus, it was late September when the agreements were

submitted to the members for ratification.

The approval process alone was a logistical marvel, and the national agreement and local contracts were ratified by substantial margins – an astonishing 92% overall.

### **The Importance of Leadership and Facilitation**

A key factor in the Partnership throughout negotiations—namely, the credibility Peter diCicco brought to the process—was also decisive in gaining initial buy-in from union leaders. Peter was widely respected by his union peers for his thirty years of experience in negotiations, as well as his success in leading coalition bargaining for the AFL-CIO’s Industrial Union Department. Moreover, he had led the effort to bring together the union coalition at KP and managed the process that led to the signing of the Partnership Agreement.

It is clear that diCicco played a key role on the union side in managing the many pressures that could easily have brought matters to an impasse. “People had to put some of their interests aside for the common good, which you don’t see every day,” said one union leader. “They had to make sacrifices, deliver some messages to their members.” Some presidents of larger locals felt initially that they could do just as well for their members by going back to the format of separate negotiations. And, in fact, some leaders played “hardball” toward the end of bargaining and threatened to pull out of the effort to reach a national agreement. As one observer stated the challenge:

*If we had not had the three years of experience with the coalition working*

*together under Pete's leadership, we never would have reached agreement. Pete had the confidence of this large group of individualists and he knew how to keep them focused on the objective of reaching a master agreement. He knew how to spell out the advantages of working together and when a leader went the other way ("let's shake the trees and see if we can get something better"), Pete stepped back and let some of the other leaders who were committed to going forward apply a little collegial arm-twisting.*

Similarly, on the management side it was critical to have a leader who had respect both from the Kaiser Foundation Health Plan and Hospitals side, and from the Permanente Medical Groups. Senior VP Leslie Margolin brought labor law, negotiations, and executive experience to the negotiations and she was a member of the KPPG. Margolin was instrumental on the management side in bringing about agreement, and she worked closely with Peter diCicco to guide an extraordinarily complicated process. She was even asked to attend union meetings to explain management proposals and to answer questions. The bridge role that Margolin played is captured in this observation from a federal mediator:

*Leslie enjoyed complete trust with the union leadership and when she said that management had "emptied its pockets" they believed her. In many ways her toughest job was keeping her management colleagues on the same page. Often when she would return from a union meeting, she would find her teammates embroiled in tense discussion and in the process of backing away from positions that they had put on the table. For example, toward the*

*end of negotiations KP's senior leadership team argued that the commitment that had been made to transmit COPE [Committee on Political Education] funds could not be done. As soon as Leslie went to the union with this change it opened the door for some union presidents to press anew for agenda items that had been dropped. She really had her work cut out for her in managing closure and achieving consensus on the part of the management group.*

Facilitation was also critical in the success of national negotiations. By now the RAI staff knew the parties very well and were able to provide training and also to help keep them on a mutual interest agenda. Many union and management leaders acknowledged the importance of the training and facilitation. Judith Saunders observed:

*I think we did a good job of training people to the process. The problem is that it is not a process that you can learn in a classroom setting and apply perfectly. It takes a concentrated effort and commitment on the part of all of the participants to understand and focus on interests, and not revert to traditional positions. It also requires knowledgeable facilitators, skilled at managing when and how to allow the parties to deviate. It highlighted that the profession could use even more facilitators with expertise in this area.*

An important innovation that RAI brought to this interest-based process is the notion that at the critical stage of focusing on agreement, the parties should be urged to identify their "make or break" agenda items. RAI consultants have learned that bargainers often find



it difficult to agree on the standards or criteria recommended in most IBN training programs. Rather, they find that the parties can usually identify the agenda items that must be resolved before agreement can be reached. So it is against this list of “must items” that any tentative agreement must be evaluated.

### Concrete Results

The substantive terms of the national agreement included a five-year contract with across-the-board wage increases between 4% and 6% for each of the five years of the agreement (RNs received higher increases than others because of labor shortages); creation of performance targets to produce savings sufficient to offset Performance Sharing Program payments of 1%, 2%, and 3% in the last three years of the contract; and numerous specific changes in practices designed to redesign and improve business systems, quality of patient care, and work processes. Pension and benefits were improved for the unionized employees in the Partnership. Further, as in the original Partnership agreement, employment security was pledged—not simple security in a particular “job,” but retraining and redeploying of workers if it proved necessary. The agreement also created a new trust fund financed at five cents per hour from employee wages (after the first year) to support training and other efforts needed to diffuse the Partnership throughout the organization. Management agreed to pay most new Partnership costs for the first year, and these were substantial.<sup>6</sup>

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<sup>6</sup> What was the cost to launch the Partnership? During the first year, KP managers estimated that the commitment to train workers (up to 40 hours per individual), plus added staff—both management and union personnel who would receive their regular pay while performing partnership duties—would amount to approximately \$12 million. After the first year, the

One of the substantive terms in the agreement was a provision for performance sharing. The document specifically states, “*performance sharing is intended to recognize that, through the Labor Management Partnership, employees and their unions have a greater opportunity to impact organizational performance and employees should, therefore, have a greater opportunity to share in any performance gains...Performance targets will be set by Region and may be based on quality, service, financial performance or other mutually acceptable factors. If targets are met, performance sharing is based on the schedule below:*

- Year 3 - 1% payout at target to be paid out in First Quarter 2003, based on 2002 performance
- Year 4 - 2% payout at target to be paid out in First Quarter 2004, based on 2003 performance
- Year 5 - 3% payout at target to be paid out in First Quarter 2005, based on 2004 performance.”

The agreement stated that a joint Labor Management Partnership would be appointed to develop a National Performance Sharing Program. Workplace Safety was identified as the key performance criterion for Years 3 and 4. The parties later jointly agreed that worker performance sharing increases would be tied to management objectives. That is, managers and partner employees would both either receive or not receive a bonus based on achievement of the same objectives.

In return, KP gained, among many other things in the relationship, five

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joint LMP trust fund would generate approximately \$15 million per year, so labor and management would move toward a sharing of partnership costs. Union members’ costs would also increase on an annual basis.

years of labor peace—a major achievement given the record of numerous strikes during the preceding decade. “Really, KP gained a substantial period of time to focus, in an uninterrupted way, on organizational performance in the areas of service, quality and cost, through the Partnership,” said Saunders. “Regardless of whether or not a union is in bargaining because its contract is about to expire, the activity around any negotiations takes the attention of the work force away from the mission of patient care.” Also, the promise of potential new KP members through joint marketing was a significant gain. Here, union leaders of the Partnership would promote KP as a “health care provider of choice” to their affiliates. And the most innovative opportunity was that for improvement of patient care and the ability to deliver it in a more participatory, cost-effective manner as a result of the joint activities fostered by the Partnership.

Dr. Lawrence summarized the value of this agreement in July 2001:

*The obvious benefits to both parties, in my mind, first of all have to do with the value of stability, in economic terms and dislocation terms, for individuals and for entities. We have created a framework that allows for productive relationships and labor management peace and stability for a period of time. So we're not rehashing conditions of work, conditions of employment, economics, every period. That has enormous benefit to the labor members because there is a certainty now, there is predictability. And it has great benefit to us. The cost of instability is high for both parties, I think. And it has economic implications; it has reputational implications.*

*That's what labor management relations do now. Labor dumps all over the company that employs them. And the company dumps all over the union and tells the world what lousy, unproductive people they are. And the consumer sitting out there says, "What in the world is going on with this organization in the long run?"*



# INCORPORATING THE PARTNERSHIP INTO ONGOING OPERATIONS

**T**he successful negotiation of the first national five-year agreement is likely to go down as a watershed event, both for the KP Partnership and in the larger context of American labor relations. But, while this agreement broke new ground on a number of fronts, it was still just a blueprint for embedding the Partnership into KP's culture and vast operations. The real work of doing so still lay ahead.

Two strategies are often used to move from agreements to build a partnership to building deep and broad-based support within the management and labor organizations and with frontline employees. One is an incremental, steady, planned diffusion across an organization that is guided by extensive investment in education and training of managers, union representatives, and employees. This approach requires considerable planning, internal negotiations over who pays for training budgets, consulting services, and other associated costs of taking time away from "normal" work activities to learn how to

integrate the Partnership principles into on-going day to day work. The second option is to pick specific projects or "naturally occurring" events or crises that occur and use Partnership principles and processes to address the underlying problems. The KP Partnership has used both approaches. We start with examples of two such 'naturally occurring' opportunities.

## **Baldwin Park**

In early 1998, KP in Southern California decided it urgently needed to open a new hospital in Baldwin Park, California. Normally, it would take approximately two years to plan and open a new hospital of this size (approximately 240 beds). The new facility was needed to come on line quickly, however, because KP's membership had grown in this area to the point that members had to be sent to non-KP hospitals for lack of capacity within the system. This was a very expensive option. Top executives at KP determined that the new hospital (which was built as a shell but not designed or staffed) needed to be

brought on line before the next winter's flu season began in the late fall.

Because the Partnership provided the opportunity for a new way of working together, a top-level decision was made to give this problem to a joint task team made up of a broad cross-section of physicians, managers, nurses, technicians, and other employees with specific expertise in how a new hospital could work. Susan Mlot and Anne Comfort were the RAI facilitators assigned to this project. Mlot recalled, "management had a lot of concern about this at first, because of both the financial and time pressures."

The partners were given a clean sheet of paper and urged to use the consensus-based principles built into the Partnership to design a hospital that all parties would experience as a positive working and healthcare environment. In April 1998, more than 150 employees, co-led by Margolin (at that time SVP & Area Manager, Tri-central Service Area, Southern California Region), her Medical Group partner Gary Lulejian, M.D., administrator Richard Rosoff, and union leaders including SEIU Local 399's Dave Bullock, United Nurses Associations of California (UNAC)'s Kathy Sackman, and SEIU Local 535's Priscilla Kania, took up this task. They brought in additional employees and managers from other medical centers that were considered leaders within their particular specialties.

These unlikely designers were trained in interest-based problem solving and consensus decision-making, visited GM's Saturn plant in Tennessee and other innovative organizations to assess different models of joint participation and co-management, and participated in what they called a five day "Blitz Week" of intensive

discussions about how to design the flow of patient care. Margolin recalls:

*The steering committee figured out the template for how to open the hospital together within six months, which seemed impossible. We decided we needed to engage people who knew about how hospital work was done—we hosted a blitz week with all classifications and unions, gave them training on Partnership principles and set them to design the hospital. We challenged them to be creative for what is best for the patient and most productive, efficient, and satisfying for employees. We had doctors and union stewards, people at all levels. The blitz week included 100 people. They would get to design the hospital, how equipment, staff, patients, would flow. We asked them to think big and bold. They did outstanding work. They broke into teams, and the Steering Committee met with the teams every night for several hours. Susan Mlot and Anne Comfort [from RAI] facilitated to keep all the teams in communication with each other. The RAI people gave them feedback. They had a lot of team spirit, cooperation. They made sure the teams were on complementary tracks.*

Anne Comfort from RAI recalls:

*After the kick-off, we had a series of subsequent meetings with what we referred to as SWAT teams. These teams were responsible for things like technology selection, vendor contracting and various other areas. A key point of the meetings was that unions would be involved in the decision-making in areas where they never previously had any say. These meetings also served to increase people's confidence that this*

*could be done if they worked on it together.*

*We had very little time to provide the actual training in the fundamentals of the Partnership. People had to get to work; there were all kinds of contractual staffing issues. During these meetings, the concept of high performance organization was also raised, but no one really had a shared understanding of what this meant. However, the expectation was that regardless of what high performance meant, the Partnership and performance had to go hand-in-hand.*

One result of the Baldwin Park experience was that individuals who had been opposed to Partnership became convinced of its value, as one union observer noted: "Rick [Rosoff, a key administrator] went through a major transformation from not thinking that the Partnership would be useful to seeing real value in the Partnership. He now believes in the Partnership. He went from the attitude of saying, 'I run this place' to being very collaborative." Dr. Gary Lulejian, the Area Medical Director, thought of unions only as "seeing people on the picket lines" before the experience. Looking back at it two years later, Lulejian said:

*I think there was tremendous value with the Partnership... I think we had great learnings by doing this together...the value is in the dialogue we had and the cooperation. We began to develop trust for each other. We also gained an understanding that we had to change the way we traditionally did things. We had to change to work as a team.*

The partners designed a hospital that focused on patient-centered care, so

that much equipment was available at bedside rather than in specialized areas that required patient transport and coordination. For instance, telemetry units, often located only in critical care units, were installed in every room, making the hospital's capacity both greater and more flexible than many other hospitals. In the end the partners were successful in designing and opening an innovative, staffed, and well designed, functioning hospital, under budget, in a virtually unheard of eight months. By opening in October, they beat the onslaught of the winter flu season. Interviews in 2001 at Baldwin Park confirmed that despite a difficult transition when senior leaders from labor and management left in early 1999, the hospital Partnership operation has continued to perform well. It is the most efficient in nursing hours per patient day of three area KP hospitals, and over the same time period, patient satisfaction has increased, according to an Operations manager. Oliver Goldsmith, M.D., medical director for the Southern California Permanente Medical Group remarked:

*This is probably the most significant venture we will do inside Kaiser Permanente over the next decade. It will serve as a building block for what lies ahead.*

### **The Optical Laboratory**

In early 1998, KP received a consultant's report indicating that closing its Northern California Optical Laboratory in Berkeley and consolidating its activities into its other lab at Glendale in southern California could save \$800,000 per year. Optical Services consists of 32 retail stores and a manufacturing facility. The glasses are made in Berkeley. The Optical Lab completes

more than 350,000 eyeglass jobs per year. “We are today the 7<sup>th</sup> largest optical operation in the US; Northern California ranks 13<sup>th</sup> in the nation” said one manager. So this was not a small decision; dozens of jobs and families were affected.

Senior management and union leaders of The Optical Lab quickly recognized this would be the most difficult, indeed, the major issue in their upcoming contract negotiations. Consistent with the Partnership’s principles, the parties agreed to try interest-based negotiations and chose a facilitator from RAI, Charlie Huggins, to train and support them through the process. Vice President and Regional Medical Group Administrator, Anthony Gately, the key management decision maker, later said candidly, “Early on I was not a proponent of the Partnership. I guess it’s because I had been working with labor for 17 years in our traditional labor-management culture of working together.” Senior management of the Optical Lab and their union counterparts were about to meet to start the process when Gately decided to join them. “If I had not been at the table, it would have been much easier to just say, ‘close it down’, without facing the consequences in a personal way. By being there I noticed first hand the pain the closure would cause”, he noted. All of them subsequently participated in interest-based problem-solving training and were charged with the task of drafting an initial statement of the issue for bargaining. However, their initial statement “Should the Optical Lab be closed or kept open?” essentially restated each of their prior “positions.” After considerable tense discussion and reminders of interest-based principles from the facilitator, the parties returned to the drafting process and restated the

issue as: “How can we contribute to KP’s turnaround by improving the performance (financial, service and quality to members) of the Optical Division?” This left both options on the table—keeping the lab open or closing it.

The parties then went into separate union and management caucuses to make sure they identified, and put on the table, their key interests. They then reconvened as a full group, outlined their interests to each other, and engaged in a process of clarifying each party’s interests by having the other side restate it in its own words. This proved to be an eye-opening experience. As Anthony Gately stated:

*We realized that there was really 80 or 90% overlap in interests—the differences were all in how we might get there. This was based on the employment security agreement, we had agreed to full employment security, no layoffs, but we would retrain or move people. When we got into the third and fourth days, we began to craft some options. That was when we began to ask, what could solve the problem? The dynamics in the room were changing by then. We had come in on opposite sides of the table, and by this time we were sitting at mixed tables. The relationships were beginning to form.*

When the parties began to brainstorm options, they came up with a remarkable list of more than 250 ideas for change and improvement in operations, many of which could save costs, increase revenues, and improve quality and service. “It was amazing,” said Gately. An SEIU Local 535 union leader, Preston Lasley, agreed, “They were really creative. For the first time,

management and union were working together.”

Some now suggest that generating the ideas proved to be the easiest part. The ideas had to be consolidated into a workable number of options. Then the parties had to agree on criteria for evaluating the options. As they worked on this phase of the process, they began to fall back into their old positions as they discussed whether the option of consolidating operations in the Glendale site could meet their criteria (one of which was employment security, another of which was saving \$800,000) and therefore should continue to be considered. They ultimately put the process back on track by agreeing to table this option, keep it in the background, and evaluate whether the others being considered could meet or exceed their required cost savings. After several days of additional intensive, heavily facilitated negotiations. The parties agreed to reorganize operations to incorporate the ideas and options generated and to review progress against cost and revenue targets after an 18-month trial. If the parties did not agree that progress during this time was adequate, the agreement could be reopened and the issue of consolidation put back on the table.

Among other things, the agreement called for an incentive gain-sharing plan based on revenue, quality, and customer satisfaction performance criteria; a change in job design and classification to create a broader utility worker job that would both increase flexibility and lower costs; and a plan to implement the Partnership principles and activities in the day-to-day operations of the lab. Implementing the agreement required more training and education, especially of the more than 210 frontline unionized

employees. Lasley recounts, looking back at it when he was interviewed in 2001:

*Well, we never had any financial information. So when Kaiser said they were losing money, nobody believed it! All of a sudden, we got the financial data. But we did not know how to read it. So we had to take finance classes. That was a very wise move. You have to know how the business actually works, the intricacies and dynamics.*

*So for instance, take measures. We have three basic measures we base everything on. The “RE-DO” includes breakage, and work that has to be done over. “TURNAROUND TIME” is how long it takes to get a product back to the local store, once we receive the order. There is a higher cost if the turnaround time is longer, and the member doesn’t get the service. And “NET INCOME.” Those were the three ‘drivers’ of the business. So, we set goals: a reasonable turnaround time, a breakage percentage (we compared ours with outside vendors), and net income. We had to meet \$800,000 savings and produce more.*

*[In choosing the measures]... they had to be things we had an ability to influence, but once we chose them, we said, we’ll depend on you to jointly determine how you meet your goals. We track all the information, and keep track of how we are doing on them all the time. Right now we have an incentive program, with those three issues. We did not want to set outrageous goals, but we did want an incentive so that it was more than normal.*



Four months into implementation of the reorganization, management reported an 8% increase in productivity, reduced turnaround time from 2.7 to 1.7 days, and cost savings that exceeded what could have been realized by closing the lab. As a result of these savings, new equipment that could expand the product offerings of the lab (by production of polycarbonate lenses) and would likely result in new jobs, was purchased.

Tony Gately summarized the results of these changes at the end of their first full year of operating under the reorganized processes:

- Net income was up 19%
- Gross revenues were up by \$5.5 million (9.8%)
- Average sales per employee were up 6%
- \$250,000 savings were realized in breakage and rework
- Turnaround time for customer delivery had declined from 2.7 to 1.3 days
- Overall productivity of the lab increased 8%
- The incentive plan produced a 2.7% payout for employees

Gately adds, "We did a review, and 21 of the 32 facilities had increased their capture rate in Optical from the optometrists by more than 1%, which added two and a half million dollars to the bottom line. It also brought more jobs into Berkeley." He then summarized his views of the role the Partnership has played both in the negotiations and in the day-to-day operations of the lab since 1998:

*It is very performance focused. I was impressed, and am still impressed, by how much labor knew the business.*

*They were never allowed to engage fully in improving the business...they had ideas, but they never surfaced, or if they did, they never went anywhere. Twenty or thirty of the ideas that came up in 1998 were major ideas. It was a learning process for me, to engage a knowledgeable workforce, and it was possible because management was ready to listen...We are still-- in 2003-- in the process of implementing some of those ideas!*

### **Other Examples of Partnership Accomplishments**

The Baldwin Park and Optical Lab projects stand out as among the most visible early uses of the Partnership and interest-based processes to address major strategic and operational challenges. The Office of LMP lists approximately 50 other initiatives that were initiated in different worksites across the KP system by early 2002. Most have achieved cost savings and/or productivity improvements. A call center in San Diego with 500 operators is often cited for its impressive gains in effectiveness, and those Partnership lessons may also be spread to a Fort Worth call center. The Glendale lab is trying out some of the Berkeley-originated ideas and adding its own. Future case documents will detail examples of these gains. Some less visible but still impressive responses to specific problems or crises also surfaced in our interviews. Consider this example of the advantage of bringing the union into a problem situation right from the beginning:

*I [a local union officer] got a call at home one Friday night from [a hospital executive, her management partner]*

*saying that, without warning, the Department of Health Services and the Fire Department were going to close a particular hospital on Monday. Within a couple hours, I had 50 people lined up, and at 10:00 a.m. Saturday morning we had the union leadership involved and we brought together a team [to work with managers]. We charted the problems. One of the union leaders used his influence with the Governor's office to gain an extra two days before the final inspection. We put every single person through rigorous training, and we got a 30-day extension about sprinkler systems in the ceiling. Although there were tons of problems, we did it. Nobody lost any pay or hours, and there was no sub-standard care. We really worked hard. We moved the staff along and transferred people temporarily as necessary to other facilities. We broke every seniority rule in the book to get this done.*

The manager referenced in this example agrees, "The union has really pulled my irons out of the fire a few times... They have a different perspective that they bring. I trust them."

Consider also this example of an Obstetrics and Gynecology (Ob-Gyn) departmental success in California, recounted by an administrator as an example of involving physicians in the Partnership:

*What we can do is to grab those pockets or those opportunities where physicians, or physician-leaders, engage in a more team-like way and solve problems in collaboration with their labor partners. I saw an example of it in Fresno in the Ob-Gyn Department that operates as a Partnership arrangement. The Chief of Ob-Gyn does not have this need to control, he's clearly a highly respected*

*individual so he de facto becomes the leader of the discussions, but the whole intent is to bring the points of view of everybody in that department to bear on solving the problems of that department. And they have. Their data suggests that patient satisfaction has gone from being in the low tercile to the top tercile in Fresno. Their wait times have dropped to almost nothing. All the different measures have improved dramatically over the last two years they've done that.*

Some examples come from process improvements, such as how grievances are handled, according to one area manager:

*One success is our issue resolution and corrective action program. Before, we used to file and dispute grievances. Now we go through an issue resolution process that occurs before grievances are filed, thereby reducing the number of grievances that actually get filed. We also have corrective action that is much more solution-oriented rather than punitive. Before, it was an adversarial, unproductive process; now we take a much more problem-solving approach. Training is very important for this, and we need to do more.*

And many improvements are hard to measure but necessary for collaborative work and innovation. For example, concerning Baldwin Park today, Dr. Lulejian stated:

*I think the really important things [we achieved] were qualitative, the way people felt about each other, the ability to set forth processes to have a springboard to do more things...I think we are leagues ahead of every other medical center in what we do, because*

*we incorporate and integrate the activities of the Partnership within the operations of the medical group...This is a matrix medical center. Things are entwined and work together. For example, I just came from a meeting of the department of pathology, and a standard part of the meeting is to report on the labor management issues within the department. LMP activities are reported in terms of education and training provided, and the impact on the department and how it impacts the workload, morale, etc.*

And some benefits accrue from realizing common interests, as one union leader pointed out:

*The unions are very committed to the Partnership. The employees have gained from job security, pay increases, job satisfaction, and more control over their work environment. The nurses think this will result in improvement for the patients...The results unions want are the same things management wants: basically a reduction in workplace problems and improvement in the "People Pulse" survey [a regular survey of employee attitudes]. KP has been an excellent employer in terms of wages, benefits, and working conditions, so this Partnership can only lead to better results for the unions.*

Another benefit of the Partnership is on the legislative front. One top KP manager says:

*It is important to think about what kind of relationship with organized labor we need to have. Also, we can work with labor on public policy issues in a more directed way, and the*

*Partnership serves as a way for us to do this. In California, 20-30% of all employees are organized. Kaiser has around 2/3 of its employees organized.*

This benefit has been realized in multiple cases. For example, KP and its unions jointly endorsed needle stick legislation in California that mandates self-sheathing needles in every healthcare workplace; some believe this could serve as a standard for the nation. KP also supported Coalition-sponsored legislation creating staffing ratios for nurses and patients. California governor Gray Davis signed such a law into effect in early 2002. It is the first state law in the nation mandating specific nurse staffing levels in hospital settings. KP and the Coalition of KP Unions have also decided to staff their nursing units at higher levels than those minimums in most cases.

These focused efforts have demonstrated the potential of the Labor Management Partnership to solve specific problems, large and small, and to respond to immediate crises. Yet for any Partnership to be sustained it must change the way workers and supervisors on the front lines do their work on a day-to-day basis. As one staff member of the Labor Management Partnership Office put it in late 2001, this task still lies ahead:

*While we accomplished some significant foundation building in 2001, the LMP has yet to achieve break-through changes in the way most employees and units work. Our aim this year is to engage many more employees and managers in jointly examining, restructuring, and improving work processes in their own areas.*

# INCREMENTAL DIFFUSION: BUILDING THE PARTNERSHIP INFRASTRUCTURE

**I**ncremental diffusion, by its very nature, reaches some parts of the organization faster than others, often creating a tension between those involved and those who continue to manage their relationships in more traditional ways.

Thus, the next key challenge facing the Partnership lies in engaging managers, physicians, union leaders, and employees *at operational levels* who are not yet involved. To help understand the nature of the journey ahead, we quote the voices of key stakeholders we interviewed. They capture the range of perspectives that will be encountered in future efforts and illustrate the internal capacity issues that need to be addressed if the Partnership is to accelerate the diffusion process and be sustained and broadened.

## **Voices of Key Stakeholders:**

### **Top Executives and Union Leaders.**

We see very strong commitment to the Partnership among top leaders in both management and unions. Both cite the trust that has developed. The strongest support for the Partnership is voiced by

executives who have had the most involvement in specific Partnership activities or projects. Consider, for example, the perspective of an executive who reflected on the imprint left on those who were most intensively involved in negotiations.

*You had 200 leaders throughout the organization with different responsibilities, spending several months with each other understanding that they were not all dragons trying to take advantage of one another, and they did share a lot of common interests and opened up communication pathways that had never existed before -- I don't think you shut that down too easily.*

Other senior executives who have been less directly involved in specific projects but participate in one or another aspect of the Partnership's governance processes learn what is involved by observing how top leaders are changing the ways they manage. Consider the following comment from a physician who has participated in top-level meetings:

*The interactions at the senior-most level are enlightening. Dale Crandall [then CFO] shares the same financial information with labor leaders and shop stewards as he does with organizational leaders. That is a huge culture change. They are open with all the books. Sometimes in National Partnership Council meetings, I can't tell who is management and who is labor.*

Yet these views are not uniform across senior executives. Our interview data captured a range of perspectives from enthusiastic to several more skeptical or cautious views among senior managers who were not ready to share decision-making power with union leaders. Consider, for example this comment from a senior executive:

*[A] Manager's mind-set is to be in control. Our managers do not want to involve unions in decision-making. They just do not have that level of trust in union employees. For this Partnership to work, there needs to be a high degree of trust.*

We know from prior studies that Labor Management Partnerships are especially vulnerable to turnover of the initial champions within senior management and labor organizations. The KP Partnership presently is working its way through such a transition as the new CEO of the Kaiser Foundation Health Plan and Hospitals, George Halvorson, takes over from retiring CEO David Lawrence. Other changes in top leadership positions have been announced and are taking place as part of this transition. Indeed, the transition itself was a source of concern to some union leaders. Early indications, however, are that Mr. Halvorson is giving high priority to

moving the Partnership forward. In a June 2002 memo outlining the make-up of his senior management team, he specifically noted the Labor Management Partnership as one of "strategic relationships" that need to be fostered and strengthened, and he appointed Leslie Margolin to a top operational leadership position.

**Physicians.** Building support among the physicians at the operational level is a key challenge for the Partnership. Support among MD's seems to lie on a continuum, partly related to the amount of exposure they have had to Partnership projects. The top-level physician leaders who lead the Permanente medical groups and sit on the KPPG all are supportive and committed to the Partnership's success. While no specific data exist that measure the degree of involvement or support for the Partnership among lower level physicians, our interview data lead us to estimate that about half the physician leaders (Physicians-in-Chief (PICs) and above) and perhaps between 10 to 15% of rank-and-file physicians have had some direct exposure to the Partnership to date. Frontline physicians are hard to engage because of the intense time pressures they work under, and because the Partnership has not yet addressed some key issues of concern to them. When the Partnership activities address clinical concerns directly, however, physician interest can be sparked and mobilized. For example, one dermatologist, a Physician-in-Chief (PIC), got very interested in a Partnership project to vaccinate adolescents, and found, to his satisfaction, that involving employees generated lots of good ideas. He also was enthusiastic when he learned that

the Partnership would help gain funding for the quality initiative.

Other physicians feel differently. Here are a few of the many opinions we heard about the challenges associated with engaging physicians and the level of their involvement up to this point:

*MD's have an interest, and sometimes need training, in the Partnership but have no time to be involved in workplace restructuring. You cannot take MD's out of the office for 16 hours of basic Partnership training. (A physician)*

*The amount of money needed for training, for structure, for union release time is incredible. There is no good structure to involve the MD's because they have to see the patients all the time. They are under a lot of pressure, too (A union leader).*

*Isn't that the group that is forcing us all to go to one day of training on our own time? (An MD to a Partnership union leader in a chance encounter on an airplane).*

*Physician involvement is variable. Some physicians are really eager and want to be involved; others could care less. Can it succeed? Don't try to involve all of them, stick with those who want to be involved. Get some success, whatever we do will be built on one small success and another success. There are enough physicians who want to be involved (An administrator).*

*The physicians really do not know about the Partnership. The ones who do know, I think are favorable if they see it as an easier way of getting their own work done. And others I think feel they are losing some power and authority. This*

*will be a struggle for us because they tend to distrust unions and think we have ulterior motives. Many of them want to continue acting paternalistic. The results they would need to see are improvements in the clinical setting and better patient outcomes. They also would probably like financial viability. I think some of them are also interested in significant policy-making results from improved clinical outcomes (A union leader).*

**Middle Management and Local Union Leaders.** All Labor Management Partnership programs, indeed, most organizational change initiatives that seek to empower frontline employees, experience challenges engaging the support of middle-level managers and union leaders. The KP LMP is no exception. One former middle manager, now leading a service area, said:

*If you look at the typical manager, they have never experienced this, and our systems are set up so it's a win-lose system. You do what I say, and if you don't, we are going to disciplinary measures. They have worked all their life to get to this job, and they feel like they're in control! And they're all pressured and trying to do stuff fast. When you put a bunch of workers and a few managers together and say, we are going to do this together—it's very difficult. Our labor force has historically not been given enough information to make these decisions. Some people have lots of education, some have none.*

*In many ways, the labor portion comes from core notions of how to do the work, and management comes to the table with the budget and information—and they have to deal with a participatory*

*process. They have to frame it, this is the outcome we want, I can suggest two ideas, do you have any ideas to suggest, and they won't always get their way...*

One local union leader's assessment suggests that movement is occurring, but slowly:

*People are starting to talk about the Partnership in different terms. We keep talking, but it's a slow process. The unions need the competency to know something about the business. We teach them a little about management, and we teach the management a little about unions. We're going to change the way we do work around here. You keep saying it over and over again and pretty soon... you start seeing people behave differently.*

One Regional manager saw parallels between the physicians and union leaders—both are parts of political organizations and need to have accomplishments to take back to their members.

*Unions bring a perspective you wouldn't have. The Health Plan and Hospitals hires and fires, just hierarchy. PMG is a political organization, and so are the unions. You have to understand what they need. I've learned to ask them, what do they need, and tell them what I need, and how do we get there, so everyone looks good. It takes a while to get there. On my side, you have to get out of command and control...My physicians in chief (PICs) are very open to the Partnership.*

At the same time, we have this point of view from a worried union leader:

*A few of us are out on a limb challenging members, and in collective bargaining the members always say "What have you done for me lately?" Partnership could end up being a lightning rod. "Could you have done more for us?" they say. Some of us have not figured out how to have a Partnership given what members want in the way of aggressive representation.*

Another union leader assesses management opinion as mixed, trying to figure out the up side for their own jobs:

*As far as management goes, I think some have bought in, some are on the fence with a wait-and-see attitude, and some just don't get it. Those who support the Partnership think they can gain a lot through promotions, raises, and financial bonus incentives. Those who don't support the Partnership think they may be giving up power and authority...The results they would need are improved financial performance, reduction of sick leave of union members, reduction in the number of grievances, reduction in the number of patient complaints, and improved service and quality.*

On the one hand, the view that "this cannot be a one-way street" illustrates a concern that surfaced in a number of management interviews, namely that the Partnership and national agreement resulted in workers gaining good wage increases, employment security, and neutrality in union organizing, among other things. Now management is looking for the workforce and union leaders to step up to the significant cost and competitive problems facing KP. At least a few do not see enough of a return

for what they see as management's "generosity" in negotiations.

*Part of the Partnership should be flexibility. Privileges and responsibilities need to be balanced. There has to be give-and-take. Unconditional employment security needs to be offset by performance (an administrator).*

On the other hand, many union leaders also believe they have made sacrifices, putting their political future with union members on the line by supporting the Partnership. Opinions vary widely by role, region, and experience. One leading union representative said,

*There are individual managers out there who have taken this and run with it, because they are good people. Managers have had no assistance in knowing how to do this. Kaiser hasn't spent near the time with their leaders as we have with ours. We have a cohesive organization with which to deliver skill building, thinking through issues, and resolving, planning for ourselves. Our steering committee is very solid, the union steering committee for the coalition, meets at least quarterly, one principal officer for each union. We've brought in people to teach us, we plan, we budget, and we try to head off trouble. We are a pretty tight group at this point. Management hasn't invested as much.*

This dual but different perception problem is a common feature of Partnership efforts. Parties on both sides often believe that they are on a "one way street" where their side has made all the contributions or taken all the risks with little return. Overcoming these opposing perceptions by making

significant and visible progress on performance, and on broadening and deepening management support, are clearly challenges to be addressed by the partners. One manager summed up the shared challenge facing management and union leaders this way:

*Something has got to happen between now and the end of 2002. It doesn't have to be a big something, but a success we can look at and say "We accomplished this together."*

Managers, and some union leaders too, were candid about their view of the need to build greater capacity and numbers within the unions involved in the Partnership:

*One of the biggest impediments right now is lack of capacity on the union side. There is only one [key union leader]. He has not developed an infrastructure that allows for any decision-making to take place without him. Things get frozen until he gets involved. On the other hand, [another key union leader from a different region] has an infrastructure and they do things without her. But she's not out of the loop (An administrator).*

*We have stewards and we are utilizing them for Partnership structures. But we only have 250 or 300 stewards for 12,000 members. We will not have a steward for every department and shift. We may recruit more; we will have members involved in the Partnership who have no other active role in the union. Our union has added some staff, but we have only five or six people for the whole country (A local union official).*



*This brings us to the problem of union bench strength. Union stewards are stubborn and do not change easily. They need to pick up a lot of new skills. These skills have to be reinforced. They also need a higher level of learning and understanding that is currently missing in most cases (An administrator).*

One union leader interviewed links this problem to the elected status of most union leaders:

*The local chairs and officers are elected. There are some good ones and some problem ones, and that affects the Partnership. You have to train them. ...The time frame [for local union leaders] is the next two-and-a-half to three years, or there will be problems because of negotiations [of the next agreements]. I am not politically vulnerable, but others are.*

Related is the danger of getting too close to management:

*Union people have to get much more sophisticated for the union members to share management responsibility or we will be seen as selling out (A different union leader).*

The best prospects for the future involved doing more work at operational levels, regionally and within specific medical centers and clinics.

*Capacity has to be built at the local level. One flaw I see with the Labor Management Partnership is that I don't believe this process can be accomplished centrally. You cannot mandate it from the top down and have people work differently together. You have to build*

*the structure locally (An administrator).*

A number of interviewees hoped union leaders could begin to represent each other in key meetings. To the extent that union leaders could do this, there would be a cadre of individuals ready to take over from others as needed. Yet this is a complicated political issue since particular union members expect to be represented by the leaders they elect. Consider the following divergent points of view on this question:

*Unions are not comfortable with representing each other. To convene one meeting with 12 unions and 10 managers could take months. We need labor partners at our decision-making tables. The goal is to have a labor rep in every key management decision-making process in the Organization (an administrator).*

*The Partnership structure and participation has led to competition among labor leaders for participation. There are just not enough resources to give everybody a voice (A union officer).*

*The unions don't get along with one another, and they have their differences, and sometimes they are very significant differences. They have to learn to accommodate one another because their structures are different. (An administrator)*

*We sometimes feel that we are on their [other unions'] coat tails; they have the power and numbers. There was a lot of distrust among the unions when the Coalition was first made; they would promise things and then leave us out in*

*the rain. We had to do a real leap of faith when all this started... That's why I like to look at people like Peter and Leslie. You have to check your baggage at the door with this [Partnership]. The trust factor was important, because we had to build a whole new relationship (Leader of a small union).*

The problem extends to those who are responsible for facilitating Partnership activities. Skilled facilitation is absolutely essential to making Partnerships work. This was abundantly clear in negotiations and early successes like Baldwin Park and the Optical Lab. The Partnership design calls for the designation and training of 16 internal consultants—KP employees who are assigned the task of facilitating Partnership activities on a day-to-day basis. The prevailing view, however, is that for the most part, these consultants are playing a limited role to date:

*The internal Labor Management Partnership consultants are very ineffective. The vision was that they should be experts. But what are they doing? They are seen as belonging to the office of LMP and they are not owned locally (An administrator).*

### **Going Beyond “Cooperation:” Balancing Partnership and Representation**

One of the key leadership challenges lies in educating labor and management representatives on how to effectively work together and balance their traditional roles and responsibilities. Two aspects of this challenge have come up in the KP LMP, just as they did at Saturn and in other Partnership settings. One issue that always requires clarification is the distinction between

*cooperation and Partnership. The distinction is easy to articulate but more difficult to put into practice. Partnership does not mean that people will always agree or that all the parties focus on a single common goal. Instead, it means that each party respects the legitimacy of the other's goals and concerns and seeks to engage in a problem solving process that addresses these various concerns. Union leaders in the KP LMP have sought to instill this perspective into joint decision-making processes. And at least one regional manager understands:*

*It did require a big change in the way we do business...although you have good relationships, there's a difference in saying to someone you are my leader-partner and you will help me with decisions vs. saying you are a great labor leader. You have to ask people first, not tell them about a decision.*

Other managers, however, see Partnership as simply workers and union leaders cooperating with management's tasks and objectives. Consider this comment from a mid-level manager:

*Most of our management does not understand the difference between cooperative labor relations and Partnership. I was very skeptical of our ability to reach an agreement that we could live up to and that could use the union's definition of Partnership.*

One senior management leader has developed his own distinctive way of working in Partnership but at the same time demonstrating his resolve to pursue his interests and responsibilities in the Partnership:

*I learned I had to change my behavior in how I interact with [union leaders]. I could not interact with them the same way as my general management style, because they are sort of in your face. So I learned to be in your face. It was very interesting because they respected me for that. I had to stand up to them when they made demands of me. For example, the union wanted a particular individual to serve on the steering committee, and we felt that person did not add value. So, I said no it was not going to happen. The suggestion was made that the person of the particular union meet with me off-line. So he and I met off-line. He said, 'this is a real political problem for me.' And I said, 'don't you understand it is a real political problem for me too?' And as we talked about what our needs were, it became very clear that we were coming from the same place. We had similar needs, and we needed to accomplish something, and we both needed to save face. The fact that I stood up to them ...caused them to go through another route where the two of us sit down and figure out what to do and discuss alternatives. So, we decided to appoint an alternative person. They were satisfied and I was satisfied and everything worked out well. If I had acted in a traditional way and given in, this would not be acceptable. I realized that I had to make a statement early on there were issues that were important for me. I was setting boundaries, and it was good learning for me and for them.*

At the same time, union leaders have to engage the business problems of their management counterparts and accept accountability for the results of the joint decisions. Unless there is an alignment of business and Partnership activities, management and workforce

commitment will eventually wane since the key problems they face are not being addressed. Our interviews suggested that the parties have a long way to go in this area, but in some cases, this appears to be happening.

*We don't want to see the Labor Management Partnership as something separate, but rather as a part of the way we work, integrated with everything else that we do (An administrator).*

And we can cite two specific examples of skeptics who are nonetheless engaging in Partnership:

*I would not be in favor of anything that diminished the ability of the physician to decide what is in the best interest of the patient in terms of providing care. In a collaborative process, the union employees and nurses can make the care experience better by us welcoming them to the table in terms of improving service. We have to integrate the people in decision-making that will yield positive results. There are small groups that need to talk about how to improve the operating room in their own areas. I have gone to several meetings where physicians, administrators, and employees are talking about what are improvement opportunities, listening to suggestions, and sending up small teams to implement possible solutions (A medical administrator).*

*One meeting I went to, there were three medical group administrators, and the doctors did not want me to be there. But the chair of the meeting insisted I should be there and said she had total confidence in my discretion. So now I go to those monthly meetings, and I have a good handle on what is going on. There is no other Service Area where we are*

*included at that level (A union official).*

Finally, decentralization presents challenges for the unions as well. One union leader said:

*When we bargained centrally, we had one team with skilled negotiators. As we decentralize, to take care of the same things as negotiations did, instead of one bargaining team, we will have one in every facility. And the issues have to be dealt with very effectively, if not more. Because they are more detailed. We have a huge range of effectiveness—we have people who are going and doing things that are really harmful, and people who are going in and doing things that our people care about.*

So the challenge, given the political realities, is how union leaders can play a co-leadership role, or at least be involved before key decisions are made, strengthen their consistency and capacities, encourage management to do the same, and at the same time remain independent and maintain the confidence of their membership.

### **Rank and File Employees.**

What about the frontline employees? How much exposure do they have to the Partnership? Again the picture varies considerably. At places like Baldwin Park and the Optical Laboratory, the Partnership is highly visible to the workforce because it was instrumental in starting the hospital and reorganizing the laboratory as well as adding incentive payments for performance there. But throughout our interviews, many agreed with the following assessment from a medical center administrator:

*There is a danger, that it [the Partnership] has not moved down to the rank and file.*

Data from a system-wide voluntary survey conducted prior to national bargaining in March 2000 reinforce this concern. Only 20% of the KP employee respondents reported they had received information or had knowledge of what Partnership activities were underway in their workplaces. By March 2002, this increased to approximately 26% system-wide with higher percentages (33%) reported among workers in California than in other Regions. This gradual increase is encouraging but also demonstrates the challenge that lies ahead. No Partnership can be sustained in the absence of a high level of knowledge, direct involvement, and the perception that tangible benefits are coming to the workforce.

Most models of union management partnerships or joint change efforts stress that, in the end, most employees will judge the effort by whether or not it produces tangible economic gains. The KP partners also recognize this principle. The 2000 collective bargaining agreement calls for a gain-sharing program to be put in place in 2002. One executive put it this way:

*... employees were very excited at first but now they feel let down, the reason being that many expectations were set, and union employees are not seeing the results. Many union employees do not fully appreciate the National Partnership Agreement. They do not recognize the value of the non-financial gains in areas such as joint staffing, quality input, and involvement in decision-making. They only want to see more dollars or wages.*

As the parties work to implement this principle, a number of generic design questions will need to be addressed. Should different Regions or operations be allowed to develop gain-sharing projects/metrics/formulae on a decentralized basis to fit their particular operations and problems or should there be a system-wide program? If local variation is to be allowed, what parameters will the projects need to meet? We have studied several locations, such as the Optical Lab and a call center, where a local gain-sharing program has been put in place. Could more of these be encouraged as a way of providing a local incentive and a very strong linkage between participation, achievement, and rewards?

Another generic question for gain-sharing programs is whether non-labor costs can be a source of savings for the performance dividend. Experience with gain-sharing plans studied at MIT's Institute for Work and Employment Research raises the possibility that if attention can be focused on economizing on non-labor costs (materials, doing things right the first time, better relationships with supervisors, harvesting the results of employee participation, etc.), that savings can be generated without any threat to employment.

### **Metrics**

Part of the partners' challenge lies in generating an agreed upon set of metrics to evaluate the Partnership. While the goals outlined in **Figure 1** provide the basic outcomes for specifying metrics, and subsequent staff work has generated a long list of specific measures to consider, the parties have yet to codify a concrete set of metrics suitable for evaluating the

Partnership. Some believe this will not be possible:

*We use metrics, but we have not separated out the metrics for the Labor Management Partnership because we have incorporated the Labor Management Partnership in our day-to-day activities so it does not stand alone, which means you cannot measure Labor Management Partnership by itself (From an administrator).*

Some metrics are more easily set and measured at the local level. In the case of the Optical Lab, the members will earn gains based on whichever is higher, the local or the national program measures. The members of the unions feel more comfortable with measures they have developed in consultation with management. Another example is within a hospital or medical center. For instance, Dr. Gary Lulejian at Baldwin Park noted, "We have the most efficient peri-operative unit in the entire program. No one in the organization can touch us. This did not happen overnight; it happened because there was a level of participation and willingness of environmental workers, nurses, physicians, and administrators with a common purpose in mind. This saved us \$1 million going from 40 minutes to 20 minutes." This is an excellent example of documenting and measuring gains to the organization achieved from Partnership work. But measuring such gains concretely is relatively rare at the local level, at least in our research to date, and these figures are not aggregated for the organization as a whole.

The LMP office has given this policy direction in relation to the 2002 Action Plan:

*To ensure workplace and performance improvement is visible to employees and physicians, we expect each work unit to have easy-to-understand barometers of progress. Sponsors have committed to making sure all employees and physicians get monthly updates on the impact of their work as it relates to workplace safety [the priority for 2002]. Adjustments to plans will be made as learning is shared across Regions. Anticipating unparalleled workplace and performance improvements, employees should economically share in the performance gains of 2002."*



# PLANNED ACTIVITIES FOR MOVING TOWARDS FULL PARTNERSHIP

**H**ow should the diffusion process proceed? Some prefer a blanket approach to educating and training people about the Partnership—speeding up the incremental process of reaching the full workforce and management structure. One union leader proposed a concrete suggestion for doing so:

*I think it would be worthwhile to rent the LA Convention Center for one week and have meetings in the daytime, evening, etc., with food, music, and presentations by key leaders and managers. Even if we only got 3,000 or 4,000 out of 20,000, the message would be sent. Now people are focusing on the written word and meetings, and relying on supervision. The training is supposed to be joint.*

Others favor taking advantage of additional pilot projects or naturally occurring change opportunities similar to the Optical Lab or Baldwin Park examples:

*How will progress happen? We will do a pilot or two and learn and design it. We cannot partner everything. It is an opportunity to show how, and that, we can work together to give experience and to generate successes (A union leader).*

*The notion is that we pick out small discrete units and give them a lot of intensive attention. Our plan is to do this lock step across the Region, with 45,000 people. We want to pick areas in the early fall and begin to experiment with 3-4 moderate size medical offices. We want to have a few jewels in our crown (A manager).*

Partnership activities have to be encouraged at all levels, from top to grassroots. In some cases, major changes will drive the need to partner effectively, as in the case of improving claims processing, where KP is upgrading its technology and productivity.



## The Strategy Group's Timetable

The Strategy Group, with staff support from the LMP, has devoted considerable time to developing a thorough set of guidelines for Year One (2002), Year Three (2004), and Year Seven (2008). We next review the top initiatives for the first two years.

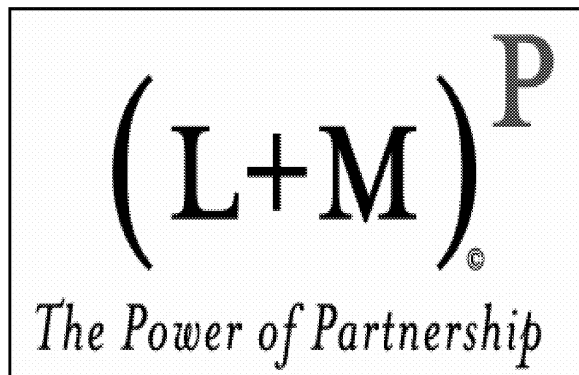
## The Workplace Safety Initiative

For the first year, workplace safety and associated cost savings have been chosen as the target. In the official words of the LMP:

*Achieving breakthrough gains in workplace safety must become the top priority for everyone in 2002. KP and partnering union leaders believe that improving workplace safety for all employees and physicians will make all other goals, objectives, and visions more achievable. Vastly decreasing the number of workplace injuries will benefit employees directly, while also building their workplace redesign skills, improving organizational performance, and demonstrating the power of the Partnership.*

A focused campaign was planned to address these costs on a system-wide basis. The LMP has developed a new logo that reads, "The Power of Partnership," complete with T-shirts and stationery. The logo itself symbolizes labor and management, exponentially raised to the power of Partnership (see Figure 6). Health and safety efforts are under way and both management and union 'performance sharing' gains will be based on achieving measurable results and improvements.

**Figure 6: The Labor Management Partnership Logo**



## Joint Staffing Initiatives

For the second year of the Performance Sharing Program (2003), the parties have also agreed to performance objectives related to management goals, thus aligning the interests of managers and Partnership-represented union employees.

While it is not part of performance sharing, in a substantive area the parties have chosen to focus on an ambitious effort to engage in joint staffing processes. Some managers are skeptical and concerned about trying this, believing it is not a subject that should be turned over to the Labor Management Partnership, since they believe management must maintain control and unilateral authority. Others, both in management and partner unions, are more hopeful:

*We are starting this year [2002] with nine or more pilots with respect to staffing. Workers should have an input as to whether there is sufficient staffing or not. It is not going to be a simple solution because of the financial realities (A union leader in Northern California).*

Regardless of whether one is skeptical or hopeful, the task will be difficult and will require careful development and planning:

*There is a whole lot of pre-work needed for joint staffing to be successful. It will take a lot of education, especially for the unions. There are various methods to do it, there is current practice, there are budgets that fence it in, and they need to work and solve system issues. They have to be prepared to look at the totality of the problem. It will be a huge effort! The unions need to buy in that the solution is not necessarily more bodies. It will be a failure for both if the fight is over bodies (An administrator).*

A union leader who is also a registered nurse sees the challenge of joint staffing in the following way, and thus not depending on 'more bodies:'

*I view it as having the right people at the right time at the right place to do the right thing for the patient. How do we figure that out jointly? It's pretty revolutionary for the health care industry to do this...[Usually] it's pretty top down. The people making the decisions don't see the outcome of their decisions. It's set up so that we get incorporated into the budget work that determines allocations for departments at the top level, and we develop facility level groups that will then figure out how many people they need of what job title, and ... more often than not, before you even know if you need to add staff—you have to figure out the system problems. So, if the drugs are not on time, and I have to look for meds for 2 hours, then I am likely to feel short staffed. But if they are on time, I don't feel short staffed. All these silos...[the*

*challenge is] trying to get them to talk to each other.*

And Optical Lab union leader Preston Lasley points out that joint staffing means different things to different unions, employees, and locations at Kaiser:

*Here in Optical we are working on our own joint staffing. We told the other unions we were not going into the national joint staffing ...We didn't want to offend anyone, but just to be practical. We will do some group trainings but keep our own identity at our own levels. Traditionally, there has been one optometrist for one optician. But that does not always work. We want to look at the statistics to see how productive each office is per Full Time Equivalent (FTE) employee. It may be that we need two opticians per optometrist. We looked at the productivity, and found it was in the medium range. We know there are some different issues, like language barriers, and ethnic issues, in the different offices. It takes longer to fit someone if you have to get an interpreter. In another office, that might be no issue. So you have to take that into account. It's also true that we have a much broader range, within the Kaiser members. We have more physically challenged people, and they take more time. You need to factor that into the system. So we need to staff San Francisco and San Pedro differently. Before, we never thought about these things.*

Joint staffing initiatives also will be affected by the lack of participation of the California Nurses Association (CNA), which represents more than 8,000 nurses working in Northern California for Kaiser Permanente. CNA,

a non-AFL-CIO union, fell out with other unions, especially SEIU which represents allied healthcare workers in the Northern California Region, at the very end of the 1997 Partnership negotiations, when CNA was still in hostile negotiations with Kaiser over staffing and wages. Various explanations underlie the split. From CNA's perspective, according to representative Jim Ryder, 90% of non-nurse KP employees honored nurse picket lines during a series of one-day strikes in 1996. By February 1998, when the Partnership was underway, only 5% did, he says. This allegation and a variety of other disagreements have left the CNA bitter at most other unions as well as at Kaiser Permanente, and hostile to any idea of Partnership. In this situation, what possibilities exist for resolving joint staffing, including nursing, in Northern California? It remains to be seen. One Northern California manager puts it this way:

*I have a good relationship with CNA as well; for whatever reasons they have chosen not to be part of the Partnership. There are privileges of Partnership and after the partner unions have gone to all the commitment to partner with us, there is always this worry, that they have made this commitment and those who have not, will reap the same benefits. On the other hand, you can't ignore the CNA nurses, because they are core to our success and our business....So I don't call CNA to help me make decisions, and I do ask SEIU to help me.*

### **KP HealthConnect**

Like his successor, the former CEO David Lawrence sees the Partnership as being one of the two biggest challenges facing KP. In Dr. Lawrence's view, the

other is the implementation of a new Clinical Information System (CIS) which evolved into the KP HealthConnect in 2003. He views these two challenges as tightly interconnected, and as a possible opportunity for joint leverage:

*AMR, [now HealthConnect] is an executive support system for clinicians [that will provide evidence-based assessments of what the current science supports in the way of caring for patients with a particular condition]. The coming together of that effort -- and it's a \$1.5 billion effort over the next 3-4 years -- is huge. That, plus the Labor Management Partnership in redesigning care organization processes. Those two are the huge bets [our organization has made for the future].*

### **Creating a Learning System**

Other organizations that have implemented fundamental change programs have often found it effective to bring together those who are making good progress with those who are struggling to get started. Various techniques are used, from forums to field trips where those considering change visit and learn directly from their counterparts who have been through a change experience. In KP, many opportunities exist to strengthen the shared learning from Partnership activities. For instance, senior managers meeting between different geographic regions could get reports on Partnership progress and challenges, and learn from each other. Middle managers and physicians, as well as local union representatives, could too.

# CONCLUDING PERSPECTIVES: RECALIBRATING THE PARTNERSHIP

This case study describes the evolution of the KP Partnership as reported to us in interviews conducted with more than 80 direct participants over the past twelve months. In this final section we offer our analysis of the current status of the Partnership and the actions needed to move it forward to realize its full vision and objectives. In doing so we draw on lessons from a variety of labor management change and Partnership building initiatives we have studied and/or been involved in directly over the years. Specifically,

- (1) We emphasize the need to apply the Partnership principles consistently at all levels of the organization and labor-management relationship—in individual workplaces and day to day decision-making, in formal negotiations processes, and in strategic decision making at the top levels of the organization;<sup>7</sup>
- (2) We stress the need for both management and union leaders

to be willing to mix “forcing” strategies to insist on use of the Partnership principles throughout their organizations with “fostering” strategies to coach individuals and facilitate joint efforts in the use of the principles;<sup>8</sup> and

- (3) We identify a set of upcoming pivotal events that, as in similar cases we have studied, will strengthen and accelerate progress of the Partnership if handled well, or lead to its demise if handled poorly.<sup>9</sup>

## General Assessment

The Partnership represents a remarkable achievement on the part of all parties. Structures and educational programs needed to prepare individuals to add value to the Partnership are in place. These could provide the

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<sup>8</sup> For elaboration on the need to mix forcing and fostering in a strategic partnership, see Richard E. Walton, Joel Cutcher Gershenfeld, and Robert B. McKersie, *Strategic Negotiations*. Ithaca, NY: Cornell ILR Press, 1994.

<sup>9</sup> For a discussion of the make or break effect of predictable pivotal events in the life of a partnership, see Joel Cutcher Gershenfeld, *Tracing a Transformation in Industrial Relations: The Case of the Xerox Corporation and the Amalgamated Clothing and Textile Workers Union*. Washington, D.C.: U.S. Department of Labor Bureau of Labor Management Relations and Cooperative Programs, 1988.

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<sup>7</sup> This framework draws on some of our prior work. See Thomas A. Kochan, Harry C. Katz, and Robert B. McKersie, *The Transformation of American Industrial Relations*. Ithaca, NY: Cornell ILR Press, 1994.

necessary infrastructure for building the Partnership. But these structures and processes are far from sufficient to achieve sustained progress. More examples of success like those of Baldwin Park, the Northern California Optical Lab, the San Diego call center, the Portland laboratories, and the OB operating room are needed to demonstrate concrete and measurable benefits to the workforce and to the bottom-line performance of KP.

Indeed, the Partnership is at a critical juncture. There is a clear sense of urgency in the minds of both labor and management leaders that calls for integrating Partnership into operations, and broadening the base of progress. If the parties do so, the Partnership will advance to gain broader support and achieve more significant results. Failure to do so, however, could result in a slow atrophy of the progress to date and/or a return to the more traditional adversarial relationships of the past.

In this respect, the KP Partnership parallels the experience of other labor-management change efforts. The expected “half-life” of prior efforts is about four years. The biggest challenges normally come when confronted with events upcoming for the KP Partners—when key leaders who championed the creation of the Partnership turn over, when competition intensifies productivity and cost pressures, or when managers and/or union leaders who have not yet signed onto the Partnership principles continue to manage or represent their constituents in traditional ways and thus block integration of principles into the daily ways of doing things throughout the organization.

## **Upcoming Pivotal Events**

### **• CEO Succession and Integration of the New Management Structure and Team**

As noted earlier, the Partnership is now moving through one key pivotal event—the transition to a new CEO and top management team of the Hospitals and Health Plan in May-June, 2002. Also as noted, early indications are that this transition appears to be serving as one of those positive, reinforcing pivotal events. George Halvorson has identified the Labor Management Partnership as a key priority for all managers, has indicated he intends to devote his personal leadership to it, and has put in place a top management team with a history of commitment to and experience with the Partnership. Among other actions, he recruited Leslie Margolin, formerly the chief management leader responsible for Partnership activities, back to Kaiser Permanente after she had resigned in February. In her new role as the national leader of Hospital and Health Plan operations, all eight Regional Presidents will report through her and she will report directly to CEO George Halvorson.

### **• Restructuring and the Kaiser Permanente HealthConnect System**

Another upcoming pivotal event lies in the introduction of the new integrated information management and delivery system, called the KP HealthConnect in an economic environment that may require workforce redeployments, and perhaps downsizing. If the introduction of this new system is handled jointly, in ways consistent with the Partnership’s principles, it could serve to reinforce and speed the diffusion of the Partnership. But if handled in what

appears to be a unilateral, top-down management fashion, it will serve as a clear example of the gap between the vision and reality of the Partnership and could provoke a Partnership-ending crisis. Other labor-management Partnerships used moments of technological change similar to this to accelerate progress and achieve substantial benefits for the organization and workforce. In the case of Boeing in the 1980s, the parties eventually put in place a joint training fund that now is used for career counseling, job-specific training, and investments in life-long learning for both production and professional employees. The introduction of HealthConnect at KP could, if implemented in a joint fashion, serve as a similar opportunity to more directly engage the workforce in improving patient care. It provides an ideal opportunity to design a roll-out process that builds on initial pilot experiences.

- **Proposed New Operating Model**

A new operating model derived from a study by outside consultants and designed around the concept of shared services is being considered within top management circles. Union leaders had not, at the time of our interviews, been involved in the discussion of this new model. This is a source of considerable concern since, if implemented, the plan would have significant effects on the role of the Strategy Group and the overall Partnership governance structure and process. Engaging union and management Partnership representatives in these deliberations would seem to be a necessary step for the new plan to be accepted and implemented successfully.

- **The California Nurses Association Relationship**

In our view, the parties' long run objective must be to bring the CNA into the Partnership. If this proves to be impossible, then both management and union partners will need to manage the complexities associated with this mixed set of union-management and inter-union relationships.

### **Building Partnership Principles into Ongoing Activities**

- **Decision-Making: Shared or Traditional** Decision-making has been shared in the deepest sense at the level of collective bargaining between the parties. However, in strategic decisions and in day-to-day operations at individual worksites, the rhetoric and language of the 2000 National Agreement and the reality are still very much at variance. We see this as the biggest question that needs to be solved by the parties: what the role of union representatives and employees should be in decision-making both at the strategic and operating levels.

Representatives from the Coalition of KP Unions are not involved in strategic level decisions in an institutionalized way. The executive director of the Coalition is allowed to attend meetings of the KPPG as a guest but not as a full member. This is far short of the shared decision-making at this level envisioned in the initial Partnership agreement. It is clearly time to revisit this initial vision and to decide whether or not to continue pursuing it on a gradual basis or to agree on an alternative model for labor's role at this level of the organization. The Partnership would be well served by clarifying what issues are to be subject to consensus decision-making, when

management should consult with union leaders prior to making a decision, and what issues management and labor should each decide on their own with simple information sharing with their counterparts.

At the operating or workplace level, some managers bring union representatives and employees into decisions before they are made. Some go so far as to involve key employees in a discussion of the problem that leads to the formulation of alternatives and the taking of decisions. However, our interviewees reported that these instances are relatively rare. As one management official put it: "Our managers are too used to a control mentality in which everything is done in terms of a hierarchy. We have to spend considerable energy reorienting our management style."

The prevailing view is captured by one of the medical directors we interviewed, who commented as follows: "The Partnership is a relationship, not a process." By this he meant that the Partnership should produce better understanding on the part of employees for the challenges faced by KP, so that they would cooperate with physicians and management as management moves forward to make decisions for the benefit of all concerned.

While this notion of "cooperation" may be an improvement over past situations where union leaders had little information or opportunity to influence management decisions, it is not the vision of the Partnership held by union leaders and some managers when it was negotiated in 1997. Nor is it consistent with the language written into the Partnership agreement. Therefore, the parties also need to revisit this issue and reach a clearer and more broadly shared

understanding of when, or over what issues, different levels of shared decision-making are expected. Indeed, this is an ideal time for the parties to refine the national agreement to bring the language of the contract into closer conformity with what is in place or able to be realized on a reasonable timetable. The goal of this process should be to achieve a shared vision over the scope and focus of the Partnership as it enters the next phase of its evolution.

- **Bring Middle-Level Leaders on Board.** While the behavior of the CEO and top Partnership executives is critical, the success of the Partnership will also depend on broadening the base of managers, physicians, and union representatives who are enthusiastic champions and skilled leaders of Partnership activities.

Enhancing Management's Role. Several tools are available for moving management away from the command-and-control style to one of fully utilizing the potential of the Partnership. Managers who have achieved bottom-line improvements through the Partnership can serve as coaches and mentors to those initiating Partnership activities for the first time. Hiring and orientation should be improved to test whether managers can work in Partnership with labor. Performance appraisal systems and promotion criteria need to give significant weight to whether or not managers implement Partnership principles into their daily activities and managerial style. The People Pulse survey could be used to benchmark the extent to which supervisors in specific units are engaging their employees in shared decision-making.

### Bringing the Physicians on Board.

Based on the experience with participatory efforts in health care organizations such as Beth Israel Hospital in Boston, it may take five to seven years to fully engage physicians in the Partnership process. Given the time and cost pressures on physicians, all MDs may never be actively involved in day-to-day Partnership meetings. One way to shorten this time span would be to identify specific chiefs of service who can serve as “champions” for this effort based on direct experience and concrete achievements with the process. Focusing on reducing medical errors as a high priority objective would also serve to engage the interests of the physician community. Where doctors have been involved, they have made a crucial difference to the success of projects. Physicians-in-Chief (PICs) may be a key group to engage, as they hold critical leadership roles. One Ophthalmology Chief, for instance, volunteered to have a doctor on the safety committee, since this was a key issue for both costs and patient care. Perhaps Partnership meetings will have to occur during physicians’ lunch breaks, if they exist, or at other times when they are not seeing patients. Another idea has been to produce a CD that physicians could play in their cars (this might work for employees too!).

### Increasing Union Leadership Capacity.

For shared decision-making to be a reality, union leaders must have sufficient background, training, and experience to participate knowledgeably and confidently in the discussions leading to decisions. Unions have begun internal training efforts. Our strong recommendation is that joint training be delivered on a “need to know” basis rather than across-the-board, to avoid

the high decay factor in learning that is not applied to concrete problems. It is important that training be done both jointly for labor and management leaders as well as in separate sessions. Regardless of how training is conducted, union leaders need to develop skills and experience in contributing to joint problem solving in the Partnership while being careful to also maintain independence and their ability to vigorously represent the interests of their members when they conflict with the interests or actions of management. Having a Partnership does not mean “throwing away the contract,” since it will still form the basis for many kinds of interactions – but the Partnership can build on the contractual language to achieve things never envisioned in a more traditional labor agreement.

### **Agents of Change**

Facilitation and process consultation are vitally important inputs for the development and implementation of productivity improvement efforts. To achieve system-wide implementation requires that resources be made available to local groups that have motivation and ideas but lack skills for moving ahead on a concerted basis. The consultants who were initially selected and trained and are now attached to the Office of Labor Management Partnership were envisioned as playing this role. Some of them are able to perform the facilitation function, but generally they are seen as more helpful for reporting on developments in their respective areas rather than serving as change agents. This means that union and management leaders will have to take on this role as an additional duty, and/or additional Partnership facilitators and coordinators will need



to be identified and developed. The role of skilled facilitators has been key in many of the accomplishments of the Partnership that we have observed.

### **Delivering Tangible Performance Improvements**

The Partnership has demonstrated its potential to deliver significant bottom-line performance improvements in a number of sites. To realize its full potential, the number of focused site-specific projects needs to be expanded. This needs to be done in a coordinated fashion so as to build on the lessons learned but with sufficient decentralized, bottom-up initiative to be tailored to specific problems and improvement opportunities.

Based on the experience of other industries, a powerful stimulus for learning and diffusion results when comparable units are brought together to hear reports about each other's progress on productivity improvement efforts. While one medical director notes that "the payoff is going to be in the quality of care and the service we give to our patients... [and] it is very hard to quantify in dollars what that is," we believe that further efforts to document the improvements are critical for credibility throughout the organization.

During the first 18 months of implementing the 2000 national agreement, the main task facing the parties has been to establish governance structures and to devolve to lower levels of the organization the principles and the deep commitment to the Partnership held by the 400 individuals who negotiated the agreement. The emphasis is shifting to embedding the Partnership at the operating level – success at this level is crucial to the long-term viability of the Partnership. Based on the experience of other

Partnerships, it is clear that without a strong foundation at the workplace, having consensus on principles in a labor management agreement and having shared decision-making at the strategic level will not be sufficient drivers to sustain the process over the long run. Alignment at all three levels (strategic, collective bargaining and operations/workplace) is essential.

### **Delivering Tangible Benefits to the Workforce**

Safety and Staffing. The Partnership will only be a success if it can deliver substantial benefits to all employees. The choice of workplace safety and associated costs as the focus for Partnership efforts in 2002 and 2003 should, if successful, serve this objective. So too should the 2003 focus on joint staffing initiatives. Both issues touch at the heart of concerns all employees have about their jobs, and both have significant upside potential for achieving the cost savings and improvements that will fund the performance sharing increments included in the contract for these years.

Daily Work Life Experience. Equally important is the need to improve the day-to-day interactions between supervisors, employees, and coworkers, and to more fully engage the talents and energies of the workforce. This will require substantial efforts to change the culture dominating interactions in many worksites, given the command-and-control traditions of many managers and supervisors.

Individual Problems and Grievances. Another area for delivering real value to the rank and file employees is in the resolution of complaints and problems at the earliest stage. The alternative

dispute resolution system envisioned in the 2000 National Agreement seeks to do just this, and implementing it across the system as soon as possible is a way of demonstrating tangible benefits from the Partnership. The experience of other Partnerships is that their Achilles' heel comes from the reality that union leaders who are spending time in joint activities may not appear able to service as well (or as immediately) the felt needs of their members. Saturn is only one of the more recent cases to experience this common problem.<sup>10</sup> This is another reason for ramping up the new dispute resolution system quickly and effectively as a very concrete way of demonstrating the value that the Partnership is delivering on the ground. Another priority is the expansion of the number of skilled union representatives, so that those who are involved in Partnership activities can be backfilled by new reps who can deal with the day-to-day needs of the rank and file.

Awareness of the Partnership. Beyond the immediate benefits, union members need to know about the accomplishments of the Partnership. Constituents need communications that demonstrate how and where the Partnership is making a difference. Making tangible what is emerging from the Partnership will help union members understand what their representatives are doing and that time spent in Partnership discussions and decisions is producing benefits. We have seen this in local areas such as the Optical Lab, but not in places where activities are not as well advanced.

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<sup>10</sup> See chapter 4 of Saul Rubinstein and Thomas Kochan, Learning from Saturn. Ithaca, NY: Cornell ILR Press, 2001.

## Challenges Ahead

In summary, the Partnership is at another critical juncture in its evolution. We observe a sense of urgency in the minds of both labor and management leaders that is motivating them to address the challenges noted above. The parties have a number of clear opportunities to do so. Taking advantage of these opportunities should serve to advance the Partnership and help broaden its base of support and impact on significant outcomes of concern to the organization and the workforce. The parties have demonstrated their ability to address challenges such as these successfully over the course of the first five years of this Partnership. This positions them well to address these current issues and similar challenges or pivotal events that will arise in the future. We have confidence the parties can meet these challenges, but it will not be easy.