

HANK

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FRONTLINE NEWS FOR KP WORKERS,
MANAGERS & PHYSICIANS



Partnership? *Really?*

IN THIS ISSUE

Metrics: Friend or foe?

Henrietta on the 'web of health'

Why this MD thinks UBTs are essential

E DITOR'S LETTER: Whose reality is it, anyway?



(L+M)^P

The Power of Partnership

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COMMUNICATIONS CO-LEADS

Maureen Anderson
Stacia Hill Levenfeld

COMMUNICATIONS DIRECTOR

Andrea Buffa

EDITOR

Tyra Ferlatte

CONTRIBUTORS

Kellie Applen, Cassandra Braun, Paul Cohen, Paul Erskine, Jennifer Gladwell, Laureen Lazarovici, Julie Light, Shawn Masten, Anjetta McQueen, Gwen E. Scott, Beverly White

Worksite photos: Bob Gumpert
Graphic design: Stoller Design Group

CONTACT US

Email feedback and story ideas to hank@kp.org.

Myths are useful when they help people understand their world. They get in the way when they prop up and lend an air of truth to outdated ideas. Fourteen years in, it's troubling there are some persistent myths, the latter kind, about the Labor Management Partnership.

Partnership is not a diabolical management scheme to hoodwink union members (one school of thought), and it doesn't exist to create a workplace where union interests rule (another school). While it brings changes, managers are still accountable for staff members' performance and unions still have a duty to represent their members. Misunderstanding partnership basics like these undermines our ability to produce superior health care outcomes.

All of us have notions we'd change if we examined them closely. Read this issue with an open mind, and if some myths ring true—keep reading. See what your colleagues have to say. And just for fun, test your LMP savvy with this quiz (more than one answer may be correct).

1. The 2010 National Agreement is:

- a) A set of suggestions.
- b) A binding contract, affecting more than 75 percent of Kaiser Permanente's workforce, signed by Kaiser Foundation Health Plan and Hospitals, the Coalition of Kaiser Permanente Unions, and all the Permanente Medical Groups.

2. When someone says they are "working in partnership," it means the person is:

- a) A wolf in sheep's clothing, likely to use what you say against you.
- b) Interested in making sure everyone involved has an opportunity to speak up and discuss how the work can be done best.
- c) Will pretend to listen but do whatever s/he wants.

3. Which of the following best describes unit-based teams?

- a) A core mechanism for improving organization performance.
- b) A natural work group of supervisors, care providers and staff members.
- c) The operating model for Kaiser Permanente.

4. In unit-based teams, managers are expected to:

- a) Coach, facilitate and support staff members.
- b) Direct the work in a top-down fashion.
- c) Use interest-based procedures to represent management priorities.

5. In unit-based teams, union stewards are expected to:

- a) Help in problem solving, leading the unit and designing work processes.
- b) Represent co-workers through interest-based procedures.

6. Using the Value Compass as a guide to decision making:

- a) Isn't optional—it's part of the National Agreement.
- b) Reminds us that value comes by improving in all four points.
- c) Keeps the focus on our members and patients' needs.

Check your answers at LMPPartnership.org. While you're there, watch the new video, "Management 101: Partnership ties my hands." And send us a line with your thoughts on partnership—email hank@kp.org. (L+M)^P

C ONTENTS

What is Hank?

Hank is an award-winning journal named in honor of Kaiser Permanente's visionary co-founder and innovator, Henry J. Kaiser.

Hank's mission: Highlight the successes and struggles of Kaiser Permanente's Labor Management Partnership, which has been recognized as a model operating strategy for health care. Hank is published quarterly for the Partnership's 120,000 workers, managers, physicians and dentists. All of them are working to make KP the best place to receive care and the best place to work—and in the process are making health care history. That's what Henry Kaiser had in mind from the start.

For information about the management and union co-leads advancing partnership in your region, please visit LMPPartnership.org.



3 PARTNERSHIP? REALLY?

If the Labor Management Partnership is all it's cracked up to be, why do we keep hearing these myths about it?

5 MANAGEMENT 101: PARTNERSHIP TIES MY HANDS

Find out about the newest video on partnership.

6 METRICS TO COUNT ON

Metrics and performance improvement are tight buddies—it's hard to know if you're improving without using numbers. So what do teams do when none of the obvious metrics work for them?

7 TIPS FOR DESIGNING, FINDING AND CREATING METRICS

Three experts give teams a head start on how to get the right data.

9 NURSES HELP NEWBORNS GET CLOSER TO MOMS

Plan, do, study, act: If your team is struggling to achieve a goal, the approach taken by this Hawaii team as it worked to increase a key practice for newborn infants might provide some ideas.

10 JOIN THE TOTAL HEALTH REVOLUTION

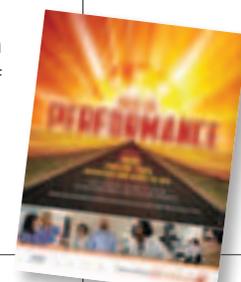
From the desk of Henrietta: Most of what ails us can't be fixed by our doctor—yet there's worlds we can do to improve our health and the health of our communities.

10 CARTOON: WORKING IN PARTNERSHIP

11 WHAT UBTS OFFER DOCS

Physicians on partnership: Why does Chris Covin, MD, the LMP physician lead at the Martinez Medical Center in Northern California, sing the praises of unit-based teams?

11 LETTERS TO THE EDITOR



Back cover poster!
Path to Performance
online tool

Partnership? *Really?*



Bust the myths. Wake up to reality on this side of the rainbow.

The Labor Management Partnership and unit-based teams are many things to many people. Proponents see the partnership as the most effective, sustainable way to improve quality and reduce costs.

But a recent informal survey revealed that some of the negative perceptions of partnership that took hold in its early days haven't gone away. The naysayers perpetuate a different view of LMP, claiming partnership is only for the union workers' benefit—or, vice versa, that management has co-opted the unions.

Going by numbers alone, there's no question that the 14-year-old partnership is touching a lot of people—as of August 2011, there were 3,411 unit-based teams working throughout Kaiser Permanente's eight regions.

Moreover, there is growing evidence that teams with strong partnership and shared decision making are definitely a “value-added” proposition. According to a 2011 study by KP Organizational Research and the Southern California Office of Labor Management

Partnership, there is a statistically significant relationship between a team's progress on the Path to Performance and key People Pulse questions—such as being encouraged to discuss errors and mistakes in the department—and between those questions and Workplace Safety performance. So, for example, injury rates were almost 50 percent lower in departments with a culture encouraging discussion, compared with departments where that was not the case.

This is the reality. It's a sign of a revolutionary cultural transformation moving KP from a typical (read: “hierarchical”) health care environment to one with, as the 2010 National Agreement says, “an atmosphere of mutual trust and respect, recognizing each person's expertise and knowledge.” UBTs drive culture and culture drives performance. This transformation is not the work of the few and the proud or the idealistic and well-meaning. It's the work of the hard-working.

“Issues will certainly always arise along the way,” says Walter Allen, executive director and chief financial officer of OPEIU Local 30 in Southern California. “The measure of our partnership will be how effectively and how quickly we can resolve those things—at the level closest to the issue.”

(continues on page 4)



Partnership? Really?

‘The measure of our partnership will be how effectively and how quickly we can resolve (issues)—at the level closest to the issue.’

—Walter Allen, executive director and CFO, OPEIU Local 30

Sharing power: John Martinez, the manager of Central Sterile Processing at the Hayward Medical Center (shown above right, in the middle, with other UBT members), says partnership helps keep the focus on issues, not individuals. His thoughts are echoed by Feras Khoury (above, inset), a manager in Fresno, who says partnership brings more predictability. Read Heath, an LVN and SEIU UWH member at Richmond Medical Center (opposite page, with a young member), says sharing power can be difficult—but the outcomes make it worthwhile.

(continued from page 3)

It’s not always easy. While managing and leading their teams, managers not only have to coach and counsel, but hire and fire. Union leaders, while taking on a commitment to jointly lead those teams, still have a duty to represent their members.

Partnership is not a silver bullet. It does not eliminate conflict. This reality feeds a set of persistent myths about partnership—myths that undermine its potential to produce superior health care outcomes.

Here, then, are nine of the top myths about partnership, debunked by those best qualified to do so: The managers, union stewards and staff members who work toward common goals, despite disagreements, day in and day out.

MYTH: “Labor Management Partnership” equals “Coalition of Kaiser Permanente Unions.” LMP represents the interests of the unions.

REALITY: The partnership is not a union organization in disguise. It is its own entity.

“The partnership represents a joint commitment by managers, workers and physicians to openly discuss ideas, perspectives and concerns to advance KP’s mission and get the best outcomes for the health plan members, patients and communities we serve,” says Pat Nunez, an assistant medical group administrator at San Jose Medical Center.

The danger of people thinking the partnership is something the unions devised to “get their way” is that it perpetuates an outdated way of working, Nunez says, with managers disinclined to bring labor to the table and labor struggling against management to be heard.

If someone—manager, union member, physician—is posturing about a narrowly defined interest, it means he or she has lost touch with the intention of the 2010 National Agreement, says Luanne Petricich, pharmacy chief in the Colorado region.

“Although (labor and management) may have different interests at times, we come together to decide what is the best solution for the patient and for the organization,” Petricich says. “Working in unit-based teams maintains a structure that promotes the Value Compass and keeps the patient/member at the center of our work.”

MYTH: The Labor Management Partnership is a way to hoodwink frontline workers. Unions that partner with employers are selling out their members’ interests.

REALITY: At its core, the Labor Management Partnership is a democratic process giving rank-and-file workers a protected means of communication about important productivity issues like workplace environment, workflow, and employee and patient safety—and the resources for working with management to improve working conditions, says Read Heath, a pediatrics LVN at Richmond Medical Center in Northern California and an SEIU UHW member and former shop steward.

“Results are evaluated by all parties concerned, to better steer the direction and nature of changes toward positive outcomes,” he says.

The partnership always has been a win-win, says Mary Lufkin, the union partnership representative for the San Jose Medical Center. “It helps us to work smarter and be more efficient. It gives us a voice. It helps us make the workplace run smoother for both labor and management. And it gives us the power to stand up for patients’ rights.”

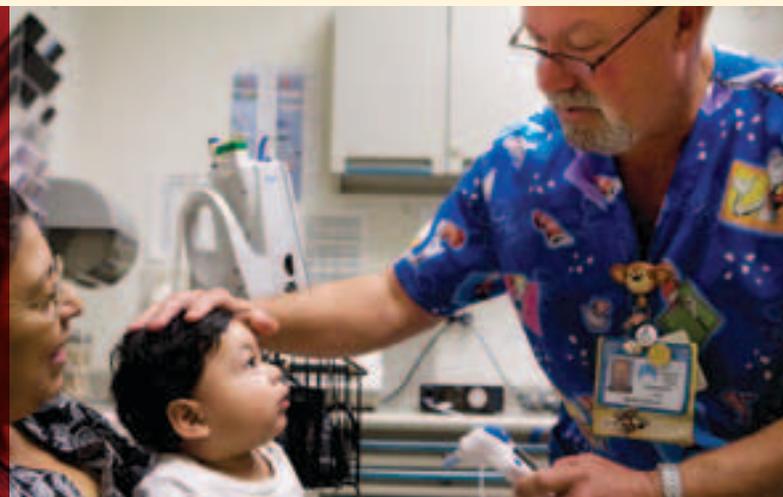
Through the partnership, both sides get new tools and approaches for solving problems based on the shared interests of all parties, including our members and patients, says Vicki Obradors-Stutson, a senior RN and UNAC/UHCP member who is labor co-lead for the Nephrology unit-based team at the Woodland Hills Medical Center in Southern California.

At sessions on goal setting and training, budget and financial management, active listening, and coaching fundamentals, she says, “Managers and their co-leads are able to learn and share together, discuss various issues and problem solve together....The tools given to us help to greatly enrich the relationship between management and labor.”

Heath agrees. “The sharing of power is always going to be a delicate and sometimes difficult process, but the potential for satisfying the basic needs of Kaiser, the workers and the members, makes partnership worthwhile.”

MYTH: Partnership means managers cannot discipline employees, and employees cannot bring grievances.

REALITY: The partnership creates a structure between management and labor that allows for a predictable method of executing discipline or grievances, says Feras Khoury, the administrative supervisor of Occupational Health/Surgery Specialties at Fresno Medical Center.



NEW!
LMP
VIDEO

NEW ANIMATED VIDEO TELLS IT LIKE IT IS

In “Management 101: Partnership ties my hands,” frontline Kaiser Permanente managers and staff members (with the help of some animated friends) talk candidly about UBTs and working in partnership.

MYTH or REALITY? Working in partnership is inefficient and slows things down.

MYTH or REALITY? Managers in unit-based teams can’t really manage. UBT co-leads must share in all decisions.

MYTH or REALITY? Partnership hasn’t given frontline staff or managers the flexibility they need.

What do they say?

- » “In the beginning, (partnership) will seem like it will take longer—and it truly does....But in the long term, it’s much better.... It does make managing it easier.”—**David Fok**, Optometry chief and manager, Diablo Service Area, Northern California
- » “Having a co-lead does not at all inhibit the work I’m doing here for the company. You do not run every decision through your co-lead....” —**Treska Francis**, manager, Medicare Risk Business Services, Colorado
- » “You don’t have the ‘that’s not my job.’ (Staff members) hop in and help wherever needed to get the needs of our members met.”—**Shannon Martinez**, nurse manager, Hidden Lake, Primary Care, Colorado

Does your experience jibe with theirs? Watch or download the video at LMPartnership.org. Get the whole skinny today! (L+M)^P

“It doesn’t prevent managers from appropriately utilizing discipline, nor does it prevent labor from exercising the right to grieve” that discipline or other actions, Khoury says.

In partnership, the focus is on the issues and not on the individuals involved, says John Martinez, the Central Sterile Processing manager and UBT co-lead at Hayward Medical Center. “Every person is accountable for their actions,” he adds. “If we get caught up in who is filing the grievance instead of why, it becomes personal. Playing within the structure of our rulebook—the union contract and the National Agreement—saves us from hard feelings and keeps the environment sound.”

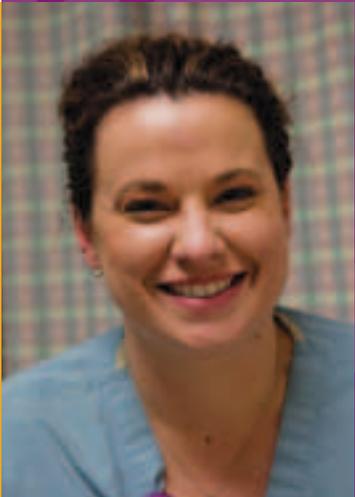
MYTHS: Departments form unit-based teams to tackle specific projects; UBT meetings are different than full team or department meetings.

REALITY: It’s easy to understand how people arrive at these closely related misconceptions. New teams have to start somewhere, usually with a project. But UBTs aren’t formed to solve individual problems; they’re the platform for doing all the unit’s daily work, including its performance improvement work. As such, then, UBT meetings are full department meetings, not project meetings.

Unit-based teams include all participants in a natural work unit or department—supervisors, union stewards, physicians and other care providers, and all the other staff members. In very large or geographically dispersed departments, the performance improvement work may be done by a committee or separate project team, but those committee members represent the interests of all the UBT’s members.

(continues on page 8)

METRICS COUNT ON



Measurement is key to performance improvement—so what do teams do when there are no obvious measures for tracking how they're doing?

Timely feedback: Tracie Girard (above and opposite page), RN, a UNAC/UHCP member at Riverside Medical Center, and Priscilla Kania (opposite page), a senior LMP consultant, are working together to develop a questionnaire so Girard's team can get the data it needs to improve patient satisfaction.



It's all about the data. The wrong data. Old data. No data.

Every day, unit-based teams aim to improve their care of patients, but for one reason or another, at times they lack the measures they need to track their progress. Then it's up to teams to create their own measures—and get the right data.

What they develop depends on the circumstances.

For example: A patient satisfaction survey was creating a head-scratcher for a facility-wide UBT at the Sugarhill Buford Medical Office Building in Atlanta. Overall dissatisfaction with the medical center was loud—but not clear.

"It's been as low as 43 (43rd percentile), and it's jumped to 65," says Jan Ritter, medical office administrator and management co-lead. Yet patients reported positive encounters, in the 90th percentile and better, with their nurses, doctors and receptionists.

The team wants to find out what's causing the split assessment, Ritter says, investigating likely culprits such as wait times: "Sometimes new members come in with the idea that it's one-stop shopping, like Jiffy Lube—in and out in 30 minutes."

The existing survey, however, doesn't provide feedback quickly enough to be able to run a test of change according to the plan, do, study, act (PDSA) steps of the Rapid

Improvement Model (RIM). Members aren't asked about their visits until a few days or weeks after their appointments. The UBT doesn't see survey results for at least two months.

The team's quest for usable metrics has become a test of change in and of itself. Its first step was to create a basic survey asking, "Were your expectations met on this visit?"

The brightly colored survey cards included space for comments and were handed out to patients during the after-visit summary. Collection boxes were placed by the exits. The response was positive (99 percent answered yes)—and, the team realized, too simplistic to be useful. Now the team is working on questions designed to distinguish individual encounters from the overall visit.

"We need to pinpoint where and why we are having problems," Ritter says.

STARTING AT THE BEGINNING

In Honolulu, the Labor and Delivery unit nurses at Moanalua Medical Center faced a different issue. Team members knew they wanted newborns to spend more time just after birth bonding with their mothers in a practice known as skin-to-skin contact, which has many benefits. But they had only a general sense of what was currently happening. Before proceeding, the team needed to develop a baseline measurement.

(continues on page 8)



'You have to come up with your own way of measuring the patients' experience with your process.'

—Priscilla Kania, senior LMP consultant

TIPS 4 DESIGNING, FINDING AND CREATING METRICS

DON'T BE CONFUSED:

When people at KP talk about metrics, they're not referring to centimeters instead of inches. "Metrics" here means "measurement."

And, says Eric Tom, LMP program manager in Hawaii, "Complex metrics can often be broken down into a few simple metrics."

Whatever your team does, remember to take note of where you started.

"I try to get teams to find a baseline," says Priscilla Kania, senior LMP consultant at Riverside Medical Center. "For example, simply ask, 'Yes or no, did your nurse show care and concern?' Then you might ask, 'What could we have done to make your experience better?' Then you take some of the ideas that patients give you and create some tests of change."

Tom, Kania and Natalie Ines White, a performance improvement adviser for UBTs in Georgia, offer these tips on how to help teams use metrics.

1. How consultants and advisers can help their teams understand and use metrics

- » Make sure teams have access to metrics.
- » Ask questions to help them understand these metrics.
- » Steer teams toward simple and easy-to-use metrics.
- » Coach teams on how to collect and track data.
- » Help teams think through what they need before they jump into gathering data.
- » Help teams understand the data source, data collection methodology and development of the performance metrics.
- » Make sure teams can chart data over time and use run charts and statistical process-control charts.

2. How teams can avoid trying to "make their numbers" rather than truly improve a process

- » Revisit the three fundamental questions from RIM:

- What are we trying to accomplish?
- How will we know that change is an improvement?
- What change can we make that will result in improvement?
- » Use automated or electronic data sources that independently measure performance; reduce or minimize manual data capture.
- » If collecting data manually, create a data collection tool/template with detailed directions.
- » Have a plan (i.e., number of records/patients; frequency: daily or weekly, etc.).
- » Incorporate balancing measures to ensure systematic changes do not produce unintended negative effects.
- » Validate performance results.
- » Conduct random data audits.
- » Remember that fewer meaningful metrics are better than more metrics that aren't focused; choose quality over quantity.

- » If data is available in KP HealthConnect, partner with an analyst to have the data pulled automatically instead of extracting it manually.

3. How teams can avoid biased or slanted measurements that don't provide an accurate representation of the real world

- » Team members should be able to define and explain SMART goals.
- » Teams should review goals with sponsors.
- » When using existing reports, understand the definition of the measures and what gets included and excluded.
- » Understand how the patient population is defined and measured.

Special thanks to Eric Tom, Priscilla Kania and Natalie Ines White. (L+M)^P

(continued from page 7)

So this summer, the RNs painstakingly took notes on every patient, recording how much contact babies and mothers had: more than an hour, less than 30 minutes, or between 31 and 59 minutes. With that data in hand, the team created a goal that was SMART (strategic, measurable, attainable, realistic/relevant, time-bound), aiming for at least one hour of skin-to-skin bonding time.

Most of the staff thought 30 to 59 minutes was sufficient, says labor co-lead Kris Oishi, RN, a member of Hawaii Nurses Association, OPEIU Local 50. "Once we educated everyone on (the need for) a minimum of one hour skin to skin," she says, "we immediately saw an increase in our percentages." (For more on the team's work, see page 9.)

Eric Tom, LMP program manager and management co-lead for the Hawaii region, notes that project-specific metrics will vary widely. A Hawaii OB/GYN team measured patient time from admission to epidural injection for a pain management project. The Ambulatory Surgery Recovery UBT gauged its recycling efforts with total weight of recyclables collected.

But in all cases, Tom says, it's critical to start a project by identifying a comprehensive set of measures and

planning how the data will be collected. This ensures baseline data is available *before* the team sets its SMART goal and streamlines the process once the project gets under way.

METHODOLOGY: PROCESS VS. OUTCOME

Teams also need to consider whether they want to measure outcomes (the final result, such as how many people with diabetes are getting retinal screenings) or process (what they have to do to get to that result).

"Regional goals are often outcome-based or (tied to) performance metrics such as HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) scores or workplace safety," Tom says. But the team-level actions that affect those scores are things such as hourly rounding on patients and having safety conversations—processes the team can track on an hourly, daily or weekly basis, providing real-time feedback that can be acted on quickly.

In Southern California, a Riverside Medical Center perioperative team initially used an outcome metric—a patient satisfaction survey—that didn't work well for it for two reasons. It wasn't reflecting the team's role in patient service, for one thing: The survey is aimed at patients who have had a stay of at least 24 hours, which omits the majority of the perioperative unit's patients, who have outpatient surgery.

"It's a good survey but was totally the wrong survey for them," says Priscilla Kania, Riverside's senior LMP consultant. Moreover, Kania says, in performance improvement work, teams often need a process measure—not an outcome measure—to determine how the system is working.

"You have to come up with your own way of measuring the patients' experience with your process," she says. "The team didn't need survey results two months from now. It needed feedback today."

The team's solution was to begin measuring patient perceptions of specific team behaviors, says labor co-lead Tracie Girard, a UNAC/UHCP nurse. She and Josephine Murphy, a clinical nursing director, took the lead in developing a questionnaire that asks patients what the unit can do to improve the care experience for members.

"All but one of the questions were designed with a 'yes' or 'no' response," says Girard. "We are off to a good start: We reviewed the first set of data in our last UBT meeting. Together, the team identified a SMART goal in UBT Tracker."

KEEPING IT SIMPLE

Finally—the data should be easy to collect.

In Atlanta, the pediatrics team at Cumberland Medical Center reduced waste simply by making pencil marks on note cards taped

to a cabinet. The UBT suspected its disorganized system for storing patient-care supplies was both creating duplicate materials and causing shortages.

It had to figure out: How do you measure wasted time and effort?

The team decided to place note cards on each of the supply cabinets. On each visit, the staff member noted what was retrieved. The team members tracked multiple trips to multiple places for the same item.

"In the next meeting, they had their tallies," says Natalie Ines White, a Georgia performance improvement adviser for UBTs. "They invited the facilities person to talk about closets and cabinets that could be used to store all inventory in one place. They discussed par levels—the maximum or minimum amount of bandages needed at a given time—and talked about inventory they could give to other departments."

In a month's time, the team documented 154 individual trips to five different supply closets. Since then, they have eliminated one closet that wasn't even in the unit and are working on consolidating everything into three closets: one for medication, one for general supplies and one for bulky orthopedic supplies.

"All of this came from thinking outside the box," says White. (L+M)^P



Partnership? Really?

'The people at the front line are the ones who see the problems and are the ones who, frequently, have the answers.'

—*Lea Hadden, medical office administrator, Panola facility, Georgia*

(continued from page 5)

"When it first started in Mid-Atlantic, there was the misunderstanding that UBTs were formed to solve problems," says Bets Bloom, the clinical operations manager for pediatrics at Gaithersburg and Germantown in the Mid-Atlantic States region. "They would work on something and when the problem was finished, people were like, 'Oh, OK, we're done.' In fact, you have a natural team and deal with issues that come up. It's an ongoing process."

Lea Hadden, medical office administrator of the Panola Medical Office Building in Georgia, says employees in her departments also held similar misconceptions at first.

"It felt like something different and separate, an assignment if you will," Hadden says. "But as we developed understanding, we saw that the full team meeting *is* a UBT meeting."

She thinks the misapprehension will correct itself the more people zero in on the purpose of the team and worry less about what the team's meeting is called.

"We need to stop focusing so much on the title and pay attention to what the work is," she says. "The work is about performance improvement. Everyone wants to do better."

Democratic process: Read Heath, a pediatrics LVN at Richmond Medical Center and SEIU UHW member, credits partnership with giving workers a protected way of communicating about important issues and providing them with new resources.

PLAN, DO, STUDY, ACT

Each issue, *Hank* features a team that has successfully used the “plan, do, study, act” (PDSA) steps of the Rapid Improvement Model (RIM). Find out about other teams’ successful practices and learn more about how to use the PDSA steps by visiting LMPartnership.org/ubt.



Nurses help newborns get closer to moms

Benefiting babies: Honolulu’s Labor and Delivery co-leads, Maji, RN, the perinatal manager, and Kris Oishi, RN, a member of HNA/OPEIU Local 50, led their team to a huge improvement in skin-to-skin contact time between mothers and babies.

Department: Labor and Delivery, Moanalua Medical Center, Honolulu

Value Compass: Quality

Problem: More newborns and mothers needed at least an hour of skin-to-skin contact immediately after birth, as recommended by the Joint Commission

Metric: Length of time newly born infants spend in direct contact with mothers

Union co-lead: Kris Oishi, RN, HNA/OPEIU Local 50

Management co-lead: Maji, RN, perinatal manager (who goes by one name)

Small tests of change: To create a baseline measure, the team developed a spreadsheet for tabulating instances of skin-to-skin contact for each patient and, using HealthConnect data, documented how much time the babies spent with their mothers. Then, members of the representative UBT did one-on-one education with fellow nurses and other staff members as well as with mothers. The team also communicated the information in informal conversations and with bulletin board posters and handouts.

Result: The percentage of newborn babies spending at least 60 minutes with their mothers in skin-to-skin contact at the time of birth soared from 4 percent of babies born on the unit in February 2011 to 71 percent in September 2011.

Background: Studies show a number of benefits for babies when they have skin-to-skin contact with their mother, without a blanket or any other barrier between them,

immediately after birth. With increased skin-to-skin time, the baby bonds better, emotionally and physically. The baby’s temperature, heart rate and breathing stabilize and blood sugar is maintained. In addition, it lays a foundation for successful breastfeeding and the numerous benefits that creates.

The team’s goal is for mothers and babies to have at least 60 minutes of this important time—allowing Moanalua to remain a “Baby-Friendly Hospital,” a title awarded by the World Health Organization and UNICEF in recognition of breastfeeding excellence and to encourage an increase in breastfeeding rates worldwide. It also supports the team’s work in increasing the number of babies who are breastfed exclusively during their hospital stay, as recommended by the Joint Commission’s perinatal core measure set. (L+M)^P



SHARE YOUR BEST PRACTICE

Has your team successfully used the PDSA steps to improve service, quality or affordability? Email *Hank* about it at

hank@kp.org.

MYTH: Unit-based teams are a “flavor of the month” and soon will be replaced by another performance improvement initiative.

REALITY: Unit-based teams are here to stay, a key component of the 2010 National Agreement between the Coalition of Kaiser Permanente Unions and KP. That binding contract states that UBTs are “the operating model for Kaiser Permanente”—our way of improving performance and quality.

There is plenty of work ahead as they become fully integrated into KP’s way of operating. All teams need to be high performing. There is a need for more consistent sponsorship of teams. The systems that support teams are still being perfected: For example, while UBT Tracker provides a powerful and necessary enterprise-wide view of the teams’ work, it currently serves top leaders better than it serves the teams themselves.

But UBTs have a staying power that lies beyond any contractual mandate. As Georgia medical office administrator Hadden says, they give workers a platform to shape their best work.

“The people at the front line are the ones who see the problems and are the ones who, frequently, have the answers,” Hadden says. “So it’s vital that they have a voice, and...freedom to address whatever comes up in their area.”

Bloom, the Mid-Atlantic manager, admits UBTs felt like another passing initiative when they first rolled out. But when she saw the results they were getting, those notions fell away. Incorporating all employees in problem solving and improving performance is the best way to provide the best possible care to members, Bloom says.

“It helps me, it helps them. It’s just a better way to work,” Bloom says. “I don’t see it going away, because it really does work.” (L+M)^P



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FROM THE DESK OF HENRIETTA:

JOIN THE TOTAL HEALTH REVOLUTION

Most of what ails us cannot be fixed by our doctors.

One study published in the *Journal of the American Medical Association* pegged direct medical care as contributing a measly 10 percent to overall health. So we're spending upward of \$2.5 trillion a year—but are we spending on the right things? Health is a web, not a straight line. Pick any point in the web, and you are surrounded by personal, organizational and social factors.

Socioeconomic status, in fact, may be the single best indicator of health. As far back as the 1970s, a study of British civil service workers showed a direct connection between job status and longevity—those on the lower rungs of the civil service ladder tended to die younger.

It's not just the Brits. Studies show that education, literacy, employment, income, family and social support, community safety, early childhood, race and ethnicity affect the health of the communities we serve.

So when we started talking about "total health" a few years back, we knew we were talking about something downright revolutionary. Traditional strategies focused on individual behavior are important—but they fall short unless social, environmental and economic factors are addressed at the same time.

So at Kaiser Permanente, we've improved food choices for employees and patients. We've started using natural building materials and cleaning solutions. We know that certain color schemes and art can speed healing, so our newest buildings take that into account.

But total health demands much more—within our walls and beyond. There is a distinct correlation, for example, between poverty, diabetes and obesity in KP service areas. Many of us live in those struggling neighborhoods—and no doubt there's a correlation between our own health and our socioeconomic status, even within the walls of KP.

KP's Community Benefit program is taking a reality-based approach.

KP has launched "a focused, collaborative effort to transform the very places where people live, work and play," says Ray Baxter, senior vice president for Community Benefit, Research and Health Policy at Kaiser Permanente. The evidence has helped us shift to "broader community priorities such as land use, violence and food insecurity."

To address the "upstream" causes of obesity, Kaiser Permanente and its community partners are creating farmers markets, installing walking and biking paths, upgrading parks and improving public transportation.

They're working to attract fresh food outlets to local "food deserts," persuading city planning departments to write health criteria into general plans, and helping schools provide healthier food and more time for physical activity.

It's a good start. And as a society we have little choice. Health care eats up a ridiculous 17 percent of the U.S. economy, and if we don't reverse the skyrocketing increases in chronic illness, we soon won't have any money left for schools, bridges or libraries.

SPINNING A HEALTHIER WEB

While our individual choices are only part of the picture, they are the easiest for us to control. Start spinning a healthier web today by taking the Total Health Assessment (THA). It's completely confidential and can help you take charge of your own health. Just do it—don't make me ask again!

Help your workplace team get healthier by joining KP Walk! and Thrive Across America.

Speak up for a new idea. Participate wholeheartedly in your unit-based team—help it use the Value Compass to guide your work. That'll be good for your health, too! Studies by Robert A. Karasek of the University of Massachusetts and by David Almeida of Penn State have shown that workers who had some control over their environment were far less likely to experience stressful conditions.

In other words: When we are engaged in a balanced, successful workplace, with mutual respect and open communication, it improves our physical health.

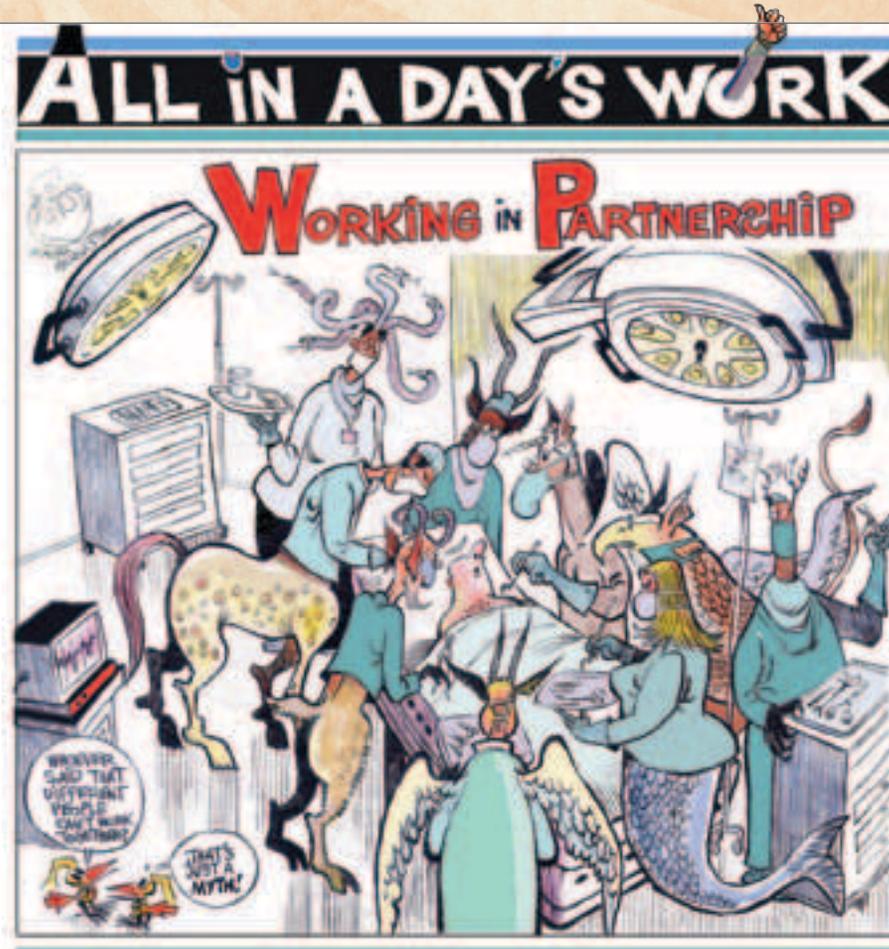
The latest KP market research has shown that consumers "get it." They know health care needs a revolution.

We get it, too. Take just one action today for total health—for yourself, your team and the communities we serve. (L+M)^P



LINKING TO TOTAL HEALTH

In every region except Northern California, access the Total Health Assessment at kp.org/hwf; in Northern California, access the THA at www.kplivewellbewell.org. Sign up for KP Walk! at www.kpwalk.com and for Thrive Across America at www.thriveacrossamerica.com.



P HYSICIANS ON PARTNERSHIP: What UBTs offer docs

'We need to foster the team approach.... One of the worst forms of waste is unused creativity.'

—Chris Covin, MD



By Christopher Covin, MD

I am a big proponent of the team approach to medicine. That's why I am an active participant of my department's unit-based team.

As the physician co-lead for the Pediatrics unit-based team, I participate in the UBT meetings both to give and to receive ideas. Ideally, a physician brings to a UBT the vision on how to work together to provide the best possible patient care, support for the management co-lead, and the willingness and openness to listen to what other people have to say.

According to Dr. Atul Gawande, noted author and surgeon, it used to be that doctors were trained to be cowboys. They worked alone and saved the day. In today's world, what people really need are pit crews, teams of people where everyone's function is vital to the overall success of the enterprise. Medicine is no longer an individual endeavor—it has grown so complex and multifaceted that no physician can know everything. So we need to foster the team approach to give our patients the best possible care.

When I first came to Kaiser nearly 10 years ago, the thing I heard that really stuck with me was the KP Service Quality credo: "Our cause is health. Our passion is service.

We're here to make lives better." I immediately connected with it and have used it to filter everything I do.

In other words, I always ask myself: Does what we are doing support our cause, passion and goal? If it does, then it's usually worth doing.

ADVICE FOR OTHER PHYSICIANS

- » Say "thank you" and say "please." Really go out of your way to appreciate someone who comes up with an idea that has made your life easier. And do it publicly.
 - » Make time for daily huddles with your staff.
 - » Create an environment in which people feel free to share their ideas. One of the worst forms of waste is unused creativity.
 - » Give people the benefit of the doubt; pause and reflect when you feel yourself getting upset.
 - » Think outside the box. Go to staff members who aren't at the nursing station to help out when needed. This gives the whole team a sense of ownership over patient care.
- Bottom line? Being a leader isn't just about being in charge. Just because you're

a physician doesn't mean you have to spearhead all of the work. If you really want to make a difference or a change, you have to include the entire staff. The work will get done better, faster and easier if we work together. And if you believe in the work that you are doing, then teamwork is a natural expression of patient care.

TIPS ON HUDDLES

Huddles are a key part of my day. At the start of each day, I review the day's schedule with the medical assistant. I look for patient names that are familiar so that we are prepared for the day's visits. For example, if I know that a patient has concerns that will likely to take up more than the usual 15-minute office visit, I will tell that to the medical assistants so they are prepared, and together, we give our patients the best care possible.

These huddles are very informal, but they go a long way toward being prepared and letting the patients know they are well cared for.

Dr. Covin is the LMP physician lead at the Martinez Medical Center and the physician co-lead for the Pediatrics unit-based team. (L+M)^P

LETTERS TO THE EDITOR



CULTURE OF SAFETY

Hank: I wanted to thank you for writing an entire issue on patient safety. As well you know, it takes all of us to create a culture of safety. I wanted to highlight the fact each medical center has an administrative team composed of experts in various fields that oversee patient safety programs. They are ready and available to serve as a resource to the UBTs.

CATHY TURNER, RN, MHA
Patient safety officer
West Los Angeles Medical Center

DEPLORABLE COVER IMAGE

Hank: I understand you intended symbolism, but I find your cover disturbing. Scuba divers armed with spears ready to harm/kill a shark is not only unnecessarily violent but environmentally irresponsible,

as it perpetuates the fear of a pretty remarkable and important animal. Separating humans from the evil ocean creatures seems contradictory for a magazine whose purpose is to emphasize unity.

ANDRÉ SHAW
Health educator
Sacramento Medical Center (Point West)

Hank: I was dismayed and offended by the cover image on your magazine. Showing an attack on a shark continues to send a bad message about a species that is already under attack by humans. Most sharks couldn't care less about us, and the great white shark attacks humans only by accident. The article about unit-based teams has nothing to do with the offending image. There are many of us who work for Kaiser who also work to preserve life elsewhere and work hard

to educate the community as well. A bit more thought should have gone into this before using this image and perpetuating an inaccurate stereotype.

NIKO J. QADDADEH
Pathology tech assistant
Santa Rosa Medical Center



CORRECTION

In "Plan, Do, Study, Act: Getting timely results for inpatient blood pressure work" in the Summer 2011 issue of *Hank*, the union that Francine Hintzman, clinical laboratory scientist at Anaheim Medical Center, belongs to was incorrectly identified. Hintzman is a member of UFCW Local 324.



PATH TO PERFORMANCE

**NEW
ONLINE TOOLKIT.
INTUITIVE AND EASY TO USE.**

GET TOOLS TO HELP YOUR
TEAM BECOME HIGH PERFORMING.

Already high performing? Get tools to help you stay on top of your game. What you need is here.

FOLD AND TEAR ALONG DOTTED LINE

