HANk

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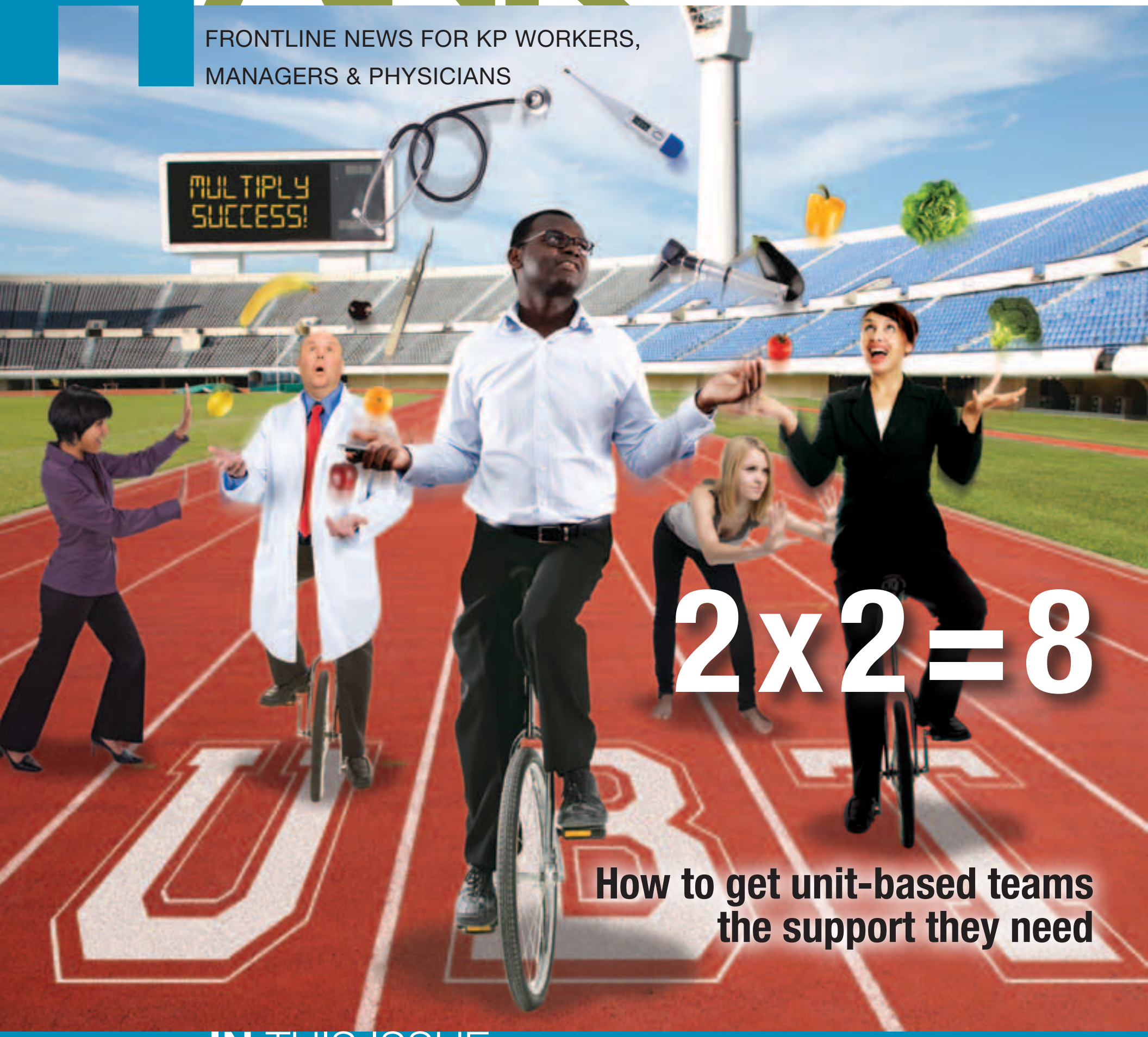
FRONTLINE NEWS FOR KP WORKERS, MANAGERS & PHYSICIANS



2x2=8

How to get unit-based teams the support they need

IN THIS ISSUE

EDITOR'S LETTER

Learning by failing

Health care, it seems, is populated with perfectionists. That's a good thing. Lab tests need to be read accurately; wrong information could be harmful. Correct, timely diagnoses can make the difference between life and death.

But a little lack of perfection here and there might be just what the doctor ordered.

Perfectionists tend to be black-and-white, either-or thinkers. Things are right or things are wrong. How something turns out is either a success or it is a failure—as in, *complete* failure. That often spills over into regarding the person associated with that "failure" as a failure, too.

It's time to introduce a few shades of gray.

The "tests of change" that unit-based teams conduct as part of the Rapid Improvement Model (RIM) are mini-experiments. If a test fails to produce the desired outcome, the failed experiment needs to be considered an opportunity—not a failure. The team has important information now that can be taken into account when the next test is run. The only failure would be to not incorporate that knowledge into the team's work going forward.

And a failed experiment does not make a failure of the person—or team—conducting the experiment. If it were otherwise, then scientists would be failures many times over. One of the activities that makes science *science* is running repeated experiments to test the validity of different hypotheses. Some succeed. Some fail. It's all part of learning.

Our society at large, however, emphasizes winning, which makes us collectively skittish about failing. We get into a habit of shying away from trying out new things.

Many—perhaps most—of us don't get good training on how to systematically set up an experiment, run it, and then learn from the outcome and apply what we learn to a next step. We especially don't get training in how to do that in a team.

That's part of why, as the "2 x 2 = 8" story that starts on page 3 points out, a UBT's ability to ask for and receive help can speed it on its way to high performance. Different kinds of help are appropriate at different stages in a unit-based team's development. Leaders everywhere are scrambling to be sure that teams get the support they need to be successful.

Successful, that is, at perfecting their ability to learn from imperfection. (L+M)P

(L+M)P
The Power of Partnership

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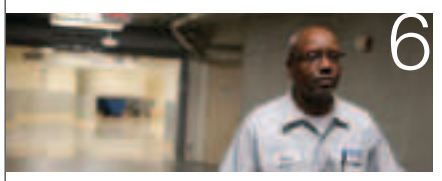

What is *Hank*?

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 LMPartnership.org.

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2x2=8

It's a tricky juggling act—getting new teams off the ground while keeping others aloft and flying ever higher. Regions and facilities alike are inventing, stretching and adapting to make sure teams get the support they need to multiply their initial successes.

Supporting UBTs: UBT consultants and part-time facilitators gather at a San Diego planning meeting, including (left to right) consultant Sylvia Wallace, senior UBT consultant Jenny Button, Stephanie Densmore, and consultants Amy Steiner and Sue Smith.

WE CREATED THEM. **NOW WHAT?**

Unit-based teams have hit critical mass, with some 86,000 workers in nearly 3,000 teams. There are hundreds of examples of the great performance improvement work that teams can do. But how will teams get the long-term support they need with the resources available? How does providing that support get integrated into the existing fabric of Kaiser Permanente operations?

While the ultimate goal is to help teams advance their problem-solving skills so they can lead their own performance improvement efforts, many leaders agree there will be an ongoing need to provide support—in some form—to UBTs.

"The worst thing we can do with the teams and individuals is let them believe that training alone will help them get better," said Matthew Taylor, Colorado's director of performance improvement. "Training is the starting place."

In facility after facility and across the regions, people are developing different ways to provide the facilitation and support teams need to take the concepts they have learned in training and put them to use in their day-to-day work. This has been particularly important in recent months, with the double demand of launching the final wave of UBTs while helping existing teams escalate their performance.

Some medical centers, like Fontana and San Diego, have created facilitator pools—groups of employees trained to support new UBTs through their beginning stages. Northern California, meanwhile, has established "resource networks," made up of leaders and project managers at a facility who have the subject knowledge and problem-solving skills to transfer to teams.

TARGETED ASSISTANCE

At Fontana and San Diego, the pools of part-time facilitators have been a big help in expanding support for teams coming on line, providing guidance as they form a charter or begin to use consensus decision making. That allows the full-time consultants and subject experts with extensive training in performance improvement to focus on working with more advanced teams.

Jenny Button, the senior UBT consultant in San Diego, says the part-time facilitators have provided invaluable support for the UBT consultants as well as the teams.

"We're not stretched as thin, because they're taking on teams," Button said. Without the facilitators, "there would be teams we (wouldn't be) able to support as well."

The part-time facilitators range from managers to medical assistants. All have shown a knack for facilitation and

(continues on page 4)

2x2=8

Helping others help themselves: Jenny Button, the senior UBT consultant in San Diego, says the pool of part-time facilitators gets UBTs the help they need (this page). Fontana part-time facilitator Geraldine Lara, an OB/GYN medical assistant, is shown here with the members of the Colton pharmacy team she worked with, including manager Edward Guerrero and pharmacy assistants Rondyna Duron and Zeucengeline Premble; Lara, Duron and Premble are members of United Steelworkers Local 7600 (opposite page, left, left to right). Kathy Brink, Fontana's lead UBT consultant, says the facilitator pool means the consultants can work with more teams (opposite page, center). Lara also worked with the Fontana engineers and material management UBT, including team member Agustin Abreo, a plant engineer and member of USWA Local 7600 (opposite page, right).

'IT'S NO LONGER JUST ABOUT CREATING A CHARTER. NOW—HOW DO YOU TEACH THEM TO TACKLE THOSE METRICS?'

—**Jenny Button,** senior UBT consultant, San Diego

(continued from page 3)

problem solving—skills usually gained or demonstrated through involvement in their own department's UBT.

San Diego's facilitator pool is modeled after one at Fontana Medical Center, which created a pool—in 2005—to help the teams coming on line there.

"The major role (facilitators) play is…to facilitate start-up processes, coach and mentor co-leads and team members, and help to transfer facilitation skills to the teams before they leave," said Kathy Brink, lead LMP consultant at Fontana. That way, she says, "we're able to work with more teams at a time."

BENEFIT TO TEAMS AND INDIVIDUALS

The facilitator pools help transfer and develop skills in more ways than one—the teams benefit, and so do the part-time facilitators. Many of them say the work has deepened and broadened their own problem-solving skills.

"As a facilitator, I've learned so much about KP," said OB/GYN medical assistant Geraldine Lara, a member of Fontana's facilitator pool.

Lara underwent facilitator training in January 2009. She works with teams over a period of six months, helping them past initial communication, meeting and project management issues.

"You ask them what they need to fix, so if they get stuck you can throw out questions," said Lara, who has worked with pharmacy and engineering teams. "You might not understand how a department works or know the lingo, but you can help them brainstorm."

Working with the UBTs, Lara says, has expanded her problem-solving skills with her own unit.

But part-time facilitator pools, as much as they are helping with the remaining wave of new UBTs, are not the full answer to providing the long-term support teams need as they accelerate performance improvement work.

"Many of our teams are well past the foundational steps. It's no longer just about creating a charter," Button said. "Now—how do you teach them to tackle those metrics? First it's low-hanging fruit, and then they need to get into meaty stuff."

To help teams do this, San Diego is turning to content specialists—experts from various disciplines and areas

who have gone through KP's Improvement Institute training and who can mentor teams on projects that cross departmental lines or are focused on such specific issues as workplace safety or service.

MATCHING EXPERTS TO TEAMS

"You have these experts out there—how do you bring them to teams when they need them?" Button said.

Northern California has taken a similar approach in providing performance improvement support for their teams. In what have been dubbed "Local Resource Networks," each facility is asked to identify individuals who can work with teams, transferring skills to team members that enable them to work collaboratively to achieve significant performance improvement.

In Colorado, where 92 percent of the workers are in unit-based teams, the plan is to create a pool of facilitators who have undergone performance improvement training and have "better-than-average skills at facilitating and practical skills in performance improvement," Taylor said. They will focus on enhancing teams' performance improvement work and supporting them in the ongoing learning process.

"We're looking at it as someone who's capable of leading the team in developing those performance improvement competencies," Taylor said. In the long term, Taylor sees the facilitators' role in Colorado not only as supporting teams' ongoing learning, but also as a critical component for leading and supporting complex performance improvement work that involves several departments.

"A lot of people understand the individual components, like root-cause analysis or process flow. But doing that successfully with all those teams across departments is a totally different ball game," he said.

Unit-based teams, he continued, "are not set up well to handle cross-departmental improvement. In my mind, that's where you need to have someone come along to help."

TURNING FAILURES INTO LEARNING

The outside observer can play another crucial function, Taylor noted: "The facilitator role or coach can come alongside as teams make failures and help turn those into learnings and provide encouragement."

Deanna Ibarra, who has been involved in Fontana's facilitator pool for the past two years, agrees that teams need checkups from time to time.

"Even when we launch a team that seems to be running well and successfully, new players come into that team all the time," said Ibarra, assistant department administrator for Support Services. "You need a facilitator to get in there and fine-tune it, or maybe down the road they need someone to come in and work on a specific issue.

"It's an ongoing process. It doesn't end when they launch."

Upland Medical Center Primary Care team members saw this last year when they launched their team with Ibarra's help. Chris Malcor, department administrator and management co-lead, says the support was invaluable.

"For a while, we didn't know what was going on," Malcor said. "Just because you go to the required training doesn't mean you know what to do with it."

Ibarra helped team members narrow the focus of issues they worked on and guided them as they incorporated performance improvement tools into their problem solving, Malcor said. Even a year later—and with several projects under the team's belt—Malcor says she couldn't imagine doing such work without the support.

"Otherwise you can get adrift. It helps frame things if you start getting sidetracked. It helps to keep you focused."

Learn more about how you could apply the ideas in this article to your region's teams by emailing Jenny Button at Jenny.Button@kp.org or Matthew Taylor at Matthew.D.Taylor@kp.org. (L+M)P

Performance improvement training is all very well and good, said Karen Price, managing consultant in the Northern California Office of Labor Management Partnership, "but if they don't have someone who can make sure they're identifying goals and testing solutions, (the training) may fall by the wayside."

"When we have someone in place who can help teams apply the learning," she continued, "it helps them integrate the new practices."

In order to sustain the success of UBTs over the long haul, Resource Networks use the natural resources within the facility—people who have skill and or content expertise. Teams can draw on support from departments such as the Employee Assistance Program, Learning and Development, Workplace Safety and Quality. The Resource Network may include leaders, project managers, consultants and frontline staff experienced in team development.

Elsewhere, the Colorado region is looking into launching a facilitator group that is a blend of Northern California's approach and the Fontana/San Diego model—with some tweaking to meet that particular region's needs.

"We've been focused for a while now on, 'How do we get more out of our UBTs?' " said Taylor, the performance improvement director.

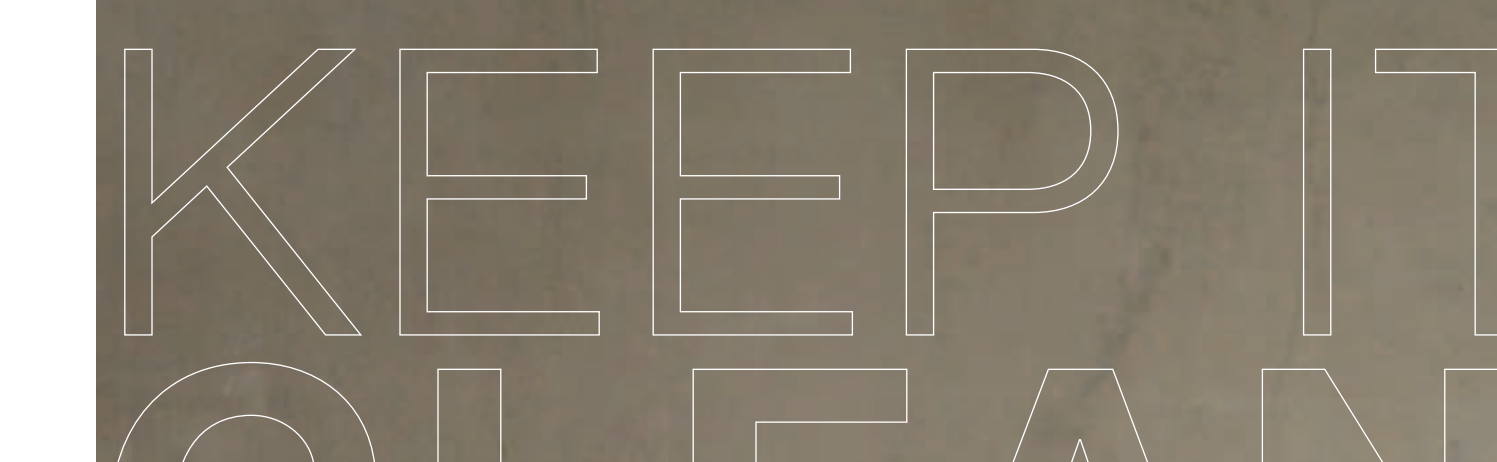
> 'You might not understand how a department works or know the lingo, but you can help them brainstorm.'
>
> **—Geraldine Lara,**
> medical assistant and part-time facilitator, Fontana

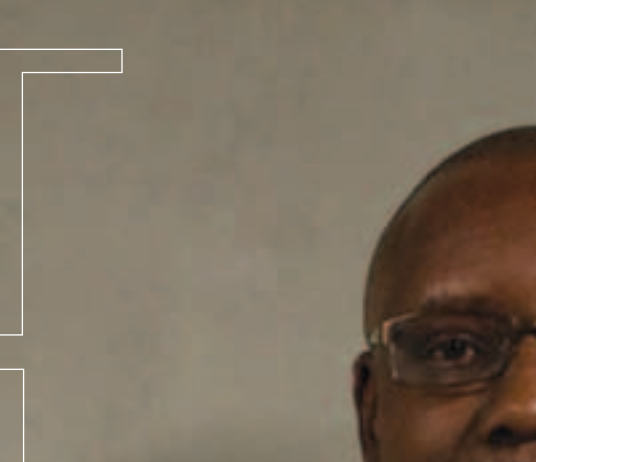
Want to test the waters?

Learn more about how Fontana's part-time facilitator pool works by watching "Supporting Our Unit-Based Teams," a 6:24-minute video that you can watch or download on the LMP website. Visit LMPartnership.org/stories-videos/fontana-attendance.

KEEP IT CLEAN

HOW EVS DEPARTMENTS ARE BUILDING A CULTURE OF SAFETY WITH PARTNERSHIP—AND CUTTING INJURY RATES





The lady who talks to you from inside your GPS has found a new home, it seems, in the robotic carts deployed in the newly rebuilt Los Angeles Medical Center.

Instead of guiding you to your destination, she's moving linen and trash along the long hallways and underground tunnels. By herself. Her gentle yet firm computerized voice tells workers in a docking room when the cart is ready to be filled, and sensors ensure she doesn't run anyone over. She even can detect whether there are passengers in the staff elevators and patiently waits for the next empty one.

Safety first: Panorama EVS attendant Rosemary Mercado (above left, and also shown on page 8), an SEIU UHW steward, says the department's unit-based team helped reduce the number of needlestick injuries. Sandra Pena, EVS labor co-lead in Riverside and United Steelworkers Local 7600 member, and her management co-lead Cora McCarthy (above center, left to right), helped their team reduce its injury rate by nearly 30 percent. Edwin Pierre (above right), a 26-year EVS worker and SEIU UHW member at Los Angeles Medical Center, says sharing data about how the team is doing helps keep team members focused.

The robotic carts reduce wear and tear on the muscles and joints of the medical center's Environmental Services (EVS) attendants. They are just one example of how managers and union members at this Southern California hospital are taking the lead in improving workplace safety for EVS departments.

Historically, EVS is a high-injury department because the job involves a lot of bending, lifting and moving equipment—not to mention working with hazardous chemicals. But the EVS department at Los Angeles Medical Center made such remarkable progress in reducing workplace injuries in 2009, its members earned a special bonus as part of the Performance Sharing Program (PSP). So did the EVS departments in Riverside and in Panorama City, which boasts the lowest injury rate in the region.

"Everyone wants to beat Panorama City," laughs Manuel Covarrubias, the building services manager there. "It's a friendly competition."

But more important than the good-humored rivalry is the confidence these teams inspire in their counterparts. "They know it can be done," Covarrubias says.

Even Kaiser Permanente's oft-stated goal of a workplace free of injuries isn't as far off as might be thought: The EVS department at the Eastside Service area in the Northwest region hasn't had a single injury for two straight years. Regionwide, the EVS departments improved their collective injury rate by a remarkable 65 percent for the reporting year ending Sept. 30, 2009.

Management and union co-leads on these successful unit-based teams credit specific safety techniques, such as pre-shift stretching, and better equipment, such as microfiber mops and motorized carts. But they also say the communication and team-building skills they use by working in partnership are crucial to building not only systems of safety, but a culture of safety.

What works

Based on the experiences of successful EVS departments in Southern California and the Northwest, here's what's working to improve workplace safety.

CONDUCT SAFETY OBSERVATIONS AND CONVERSATIONS

At Riverside Medical Center in Southern California, the management and labor co-leads of the EVS unit-based team conduct safety observations together. "We walk the units and look for safety hazards," explains Cora McCarthy, EVS manager.

> 'There are still issues we disagree about, but before, we used to get nothing solved. Now, issues get solved and they are off the table.'
>
> —**Dilcie Parker,** EVS labor co-lead and SEIU UHW member, LAMC

Evidence from Sunnyside hospital in the Northwest shows the effect this kind of effort can have. After the injury rate jumped up in the first half of 2009, Curtis Daniels, the medical safety coordinator, challenged UBT members to see how many safety conversations they could have to raise awareness of potential hazards. More than 6,000 conversations were reported in one month alone—and during the second half of 2009, the inpatient teams had only two workplace injuries.

BY THE NUMBERS

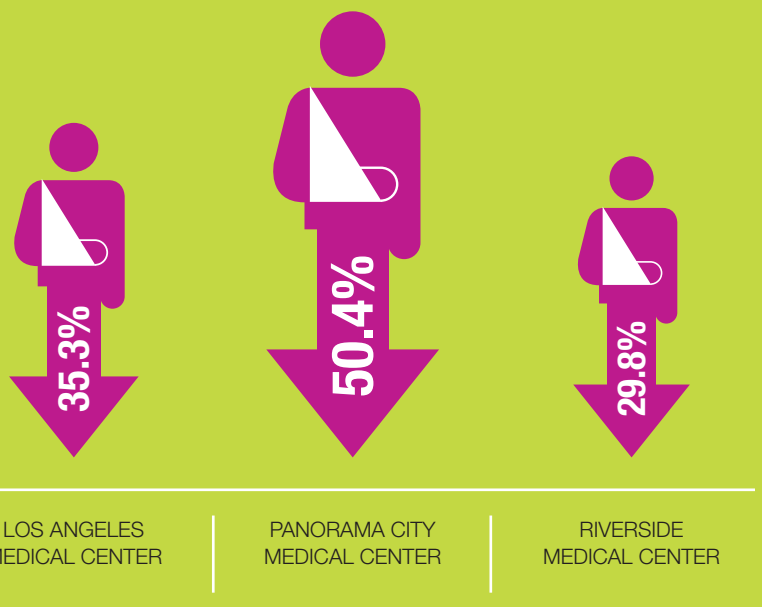
The successful teams collect, track and—most importantly—*share* data, information and tips about workplace safety.

In Southern California, for instance, where there has been a 33 percent reduction of accepted workers' compensation claims since 2005, the regional Workplace Safety department has built a customized incident investigation database, harnessing data that helps teams spot trends and come up with solutions. The database is only useful because employees are willing to report the injuries they suffer.

(continues on page 8)

Reducing injury rates, SoCal style

As part of a programwide push to more closely tie the work that frontline managers and employees do day to day with year-end performance bonuses, the LMP regional council in Southern California established a "line of sight" Workplace Safety goal for EVS departments. The three best-performing medical centers, which were the only teams to meet the goal and get the bonus, had these percentage drops in their injury rates from 2008 to 2009.



Accelerating improvements in workplace safety

In February, Bernard Tyson, executive vice president, Health Plan and Hospital Operations, asked hospital executives to take several steps to further reduce workplace injuries. One of the steps is to implement these 12 evidence-based safe-housekeeping practices recommended by the federal Occupational Safety and Health Administration (OSHA):

01] **Alternate leading hand.**

02] **Avoid tight and static grip and use padded non-slip handles.**

03] **Clean objects at waist level if possible, rather than bending over them.**

04] **Use knee pads when kneeling.**

05] **Use tools with extended handles, or use stepstools or ladders to avoid or limit overhead reaching.**

06] **When sweeping or dusting, use flat-head dusters and push with the leading edge; sweep all areas into one pile and pick up with a vacuum.**

07] **Use mops with light heads, such as fiber mops.**

08] **Frequently change mopping patterns (push/pull; figure 8; rocking side to side) to alternate stress on muscles.**

09] **Be sure buckets, vacuums and other cleaning tools have wheels or are on wheeled containers with functional brakes. Use carts to transport supplies rather than carrying.**

10] **Alternate tasks or rotate employees through stressful tasks.**

11] **Use buffers and vacuums that have lightweight construction and adjustable handle heights.**

12] **Use spray bottles and equipment that have trigger arms rather than single-finger triggers.**

Visit www.osha.gov/SLTC/etools/hospital/index.html for more information.

KEEP IT **CLEAN**

How to spread successful practices

GET IDEAS, SHARE IDEAS—HERE ARE SOME SUGGESTIONS ON DOING THAT:

- Convene a regular EVS peer group, made up of department managers from each facility in the region, as is done in Southern California.
- Visit the national Workplace Safety intranet site at http://kpnet.kp.org:81/wps.
- Involve an EVS employee on inpatient unit-based teams, as is done in Panorama City.
- Watch a video of the Riverside EVS team on the LMP website at LMPartnership.org/stories-videos/ubt-riverside-evs.

(continued from page 7)

"At first, people were afraid," says Eva Gonzalez, an EVS attendant at Panorama City and an SEIU UHW steward. "We assure them there is not going to be a backlash. Incident investigations helped, because people would show us how they got hurt and we let them say what happened. We ask, 'What do you think we should do differently?' "

Ofelia Leon, the day shift supervisor who has worked at Kaiser Permanente for about three years, notes the fear of reporting was not unfounded: "At other (non-KP) hospitals, if you got injured, you got a caution or discipline, so people were afraid to report them."

Employees also get regular updates about their progress toward their workplace safety goal. "We share information and let our members know where we're at and where we need to be," says Edwin Pierre, a 26-year EVS worker at LAMC. A huddle at the beginning of each shift includes a safety tip shared by an employee —creating a climate where workers get accustomed to speaking up and gain confidence that their voices are being heard.

FLOOR IT, SAFELY

To reduce injuries from lifting bulky mop buckets, EVS departments are buying more efficient microfiber mops that don't require as many trips to empty, are wringerless, and use less water and cleaning solution. To keep those long hallways at LAMC clean while keeping workers safe, the EVS department replaced autoscrubbers with "chariots" that workers ride. "They have improved quality and morale, as well as safety," says Abraham Villalobos, the hospital's director of Environmental Services.

MAXIMIZE THE MICRO

Microfiber is not just for mops. EVS departments in the Northwest now are using microfiber dusters with extendable handles proven to reduce worker strain. The new dusters also clean 45 percent faster than traditional methods and reduce chemical and water consumption up to 90 percent.

TAMPER WITH HAMPERS

The lids on trash cans and hampers were falling on workers' arms and causing injuries—so the Panorama City EVS department bought new bins with hydraulic lids. They also put signs above hampers asking staff members not to overload the bins, because too-heavy loads were causing lifting injuries.

In a similar vein, "when needlestick injuries were up, we brought it to the table," says Rosemary Mercado, an EVS attendant and SEIU member at Panorama City. The unit-based team decided to coach workers to hold the bags away from their bodies when taking them out of the laundry hampers. And they borrowed an idea from colleagues at nearby Woodland Hills Medical Center: They moved the hampers away from the sharps containers.

TAKE YOUR TIME, TAKE TIME OFF

"Be careful and take your time," is the advice from Rebeca MacLoughlin, a housekeeper in the Northwest for seven years. Mindful of the link between fatigue, morale and injuries, building services manager Manuel Covarrubias in Panorama City encourages employees to take time off when they seem to be getting sluggish. "I look for ways to cover people during summer to ensure people with less seniority can get some time off when they really want it," he says.

STARTING WITH STRETCHING

Without exception, every EVS department that's been successful at reducing the injury rate starts every shift with stretching. "Sometimes we dance and make it fun," says Ofelia Leon, the day shift supervisor at Panorama City. The dance music of choice at LAMC is Michael Jackson. "I mean, who can't dance to Michael Jackson?" wonders Pierre, the LAMC EVS attendant.

'Now, it's like there's feedback back and forth all the time. **It's more of a team.**'

—**Sandra Pena,** EVS labor co-lead and USWA Local 7600 member, Riverside Medical Center

THE BOTTOM LINE

Investigating incidents, sharing safety tips, having on-the-spot conversations about working safely: These things are possible in large part because of the communication and team-building foundation fostered by the Labor Management Partnership.

Before, "It was just coming to work, doing whatever, and then leaving," says Sandra Pena, the EVS labor co-lead at Riverside and a United Steelworkers Local 7600 member.

"Now, it's like there's feedback back and forth all the time. It's more of a team."

"It makes you feel good as an employee to make improvements," says Eva Gonzalez of Panorama City. "We know our opinions matter. We know we are not talking to the wall."

Dilcie Parker, the EVS labor co-lead and an SEIU UHW member at LAMC, recalls how things were in 1999, when partnership started taking hold at her facility. "When we first began meeting, it was, 'You sit on that side of the table, I sit on this side.' I once arrived at a meeting and said, 'I don't sit next to management.' You could feel the hate in the room."

Management co-lead Villalobos doesn't disagree. "Before, we couldn't stand each other," he says. "There was screaming."

The turnaround, both say, came as a result of the LMP training the whole team received—from mapping root causes to issue resolution—and persistence.

"We started seeing the benefits in better quality and better attendance," says Abraham Villalobos. "The reduction in injuries didn't just happen this year. It's about understanding the things we need. If we don't get along, we can't come up with projects to work on."

This doesn't mean everyone is holding hands and singing "Kumbaya."

"There are still issues we disagree about," says Parker. "But before, we used to get nothing solved. Now, issues get solved and they are off the table." Recently, Parker, Villalobos and the team were in a meeting, crammed together in a tiny conference room. The woman who once refused to even sit next to a manager found herself saying, "Look, Abraham, we're actually touching."

For information about EVS teams in Southern California, contact Dave Greenwood, workplace safety program director, at Dave.B.Greenwood@kp.org; for more information about workplace safety for EVS teams in the Northwest, contact Lori Beth Bliss, regional EVS manager, at Lori.B.Bliss@kp.org. (L+M)P

'WE LOVE TO SAVE TIME'

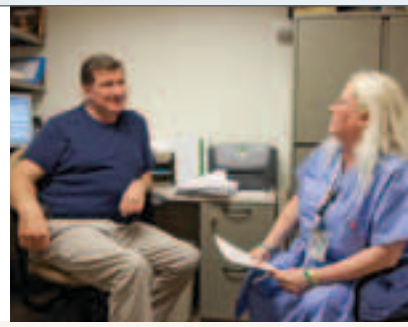
CORRECTION

Hank regrets that most of the photos accompanying the story **"We Love to Save Time"** in the Spring 2010 issue did not portray the key members of the unit-based team at Irvine Telemetry who successfully implemented the hourly rounding system.

Here they are, pictured with Chief Nurse Executive Karolynne Johnson, who is leading the charge for hourly rounding hospitalwide. FROM LEFT TO RIGHT: Jennifer Nanasca, RN; Edward Saberon, RN; Jun Jiyeon, RN; Sandra DelaCruz-Davis, monitor technician; Rupinder Maan, RN; Lolita Pelino, ward clerk; Johnson; Nenita Nave, nursing assistant; Lloyd Maderazo and Mervin Francisco, both assistant department administrators; Miah Galindo, RN; Ruby Gill, clinical director, Medical-Surgical/Telemetry; Jennifer Eusoof, assistant department administrator; and Christy Garcia, RN. Nanasca, Saberon, Jiyeon, Maan, Galindo and Garcia are members of UNAC/UHCP; DelaCruz-Davis, Pelino and Nave are members of SEIU UHW.

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' best practices and learn more about how to use the PDSA steps by visiting: **LMPartnership.org/ubt.**



Pain, pain, go away

Teamwork: Gary Kienbaum, the PACU and Surgery Center manager, talks with his labor counterpart, RN Ravida Benjamin, an HNA member (above right, left to right).

Department: Post-Anesthesia Care Unit (PACU), Moanalua Medical Center, Honolulu

Value Compass: Quality, service

Problem: Inconsistent pain management

Metric: Pain levels of PACU patients

Labor co-lead: Ravida Benjamin, RN, HNA

Management co-lead: Gary Kienbaum, manager, PACU and Surgery Center

Test of change: Training recovery and preoperative nurses in consistent ways to measure and manage patient pain levels.

Result: A 35-point improvement in patient pain management. In November 2009, 60 percent of patients were discharged from the unit reporting a "tolerable level of pain." In January 2010, 95 percent of patients reported that level, indicating that pain levels are properly managed.

Next steps: Continue to monitor patient pain levels consistently until reaching 100 percent pain level management. Team also plans to coach other nursing units on pain management—and to examine how proper pain management affects patient satisfaction scores, a regional goal.

Biggest challenge: "Our biggest issue was inconsistency from staff member to staff member in how they assessed pain and how they documented pain," says Kienbaum, adding that the entire team needed to be re-educated to explain to patients how to describe their pain on a 0-to-10 scale. For example, if a patient states a pain level of 3 or 4 but is clearly not comfortable, the nurse would want to ask them more questions to get the patient's true comfort and pain level, which might be higher on the scale.

Background: The PACU treats patients recovering from surgery and other procedures, and is usually the point of discharge. The goal is to send patients home with their pain levels as low as possible or under proper management with medicines and other treatments such as therapy.

The team, reviewing patient charts, found the same patient had widely varying levels of pain recorded by different nurses in a short period of time. Team members thought this variation undermined the patient's treatment, comfort level and satisfaction.

"We wanted to make sure these patients were getting properly medicated," Benjamin says. The first small test of change involved devising a standardized set of questions for the nurses to ask—and document—regarding patient pain. Once nurses were complying at a high level in the recovery unit, the team moved on to another test of change: involving the pre-admission unit.

Patients themselves also were educated on pain level questions before surgery, with cards and descriptions of the 0-to-10 pain scale.

"Often when you have had general anesthesia, it's not a good time to be teaching patients on pain management," Benjamin says. "We felt that before they went into the procedure, they should understand what the recovery room nurses would be asking them."

Could this team's tests of change be modified for your UBT? Email Gary.R.Kienbaum@kp.org or Ravida.Benjamin@kp.org to learn more. (L+M)P

> 'Our biggest issue was inconsistency from staff member to staff member in how they assessed pain and how they documented pain.'
>
> —**Gary Kienbaum,** manager, PACU and Surgery Center

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**.

FROM THE DESK OF HENRIETTA: SMALL IS BIG

Small change isn't just for the crevices in your couch. That's one of my favorite sayings, and one I think we all can benefit from remembering.

Including me. Even as I sat down to write this piece, I forgot the very thing I was trying to remind all of us about—that small, simple approaches can, and do, have a big impact. I proceeded to get bogged down in compiling numbers, culling examples and designing an ambitious treatise to make my case. I froze, stumped, cursor blinking infuriatingly at me for the next word.

Sometimes when we think big (which is not a bad thing, by the way) we can get tripped up, tangled and strangled by monumental thinking. The vision turns into an unwieldy monster we can't begin to figure out how to start tackling.

The always irreverent writer Anne Lamott, who is quite familiar with how easy it is to become overwhelmed by the "big," said it best. You do it "bird by bird." Sometimes you tackle the monster small piece by small piece, small change by small change.

WHAT'S GOOD FOR THE GOOSE

You don't have to strain your neck to see endless examples of teams that have seen success with tiny tweaks, or in Kaiser Permanente parlance, "small tests of change." And they illustrate over and over again why small changes are an effective approach to problem solving. They're often easy, usually inexpensive and frequently require little infrastructure. It's an approach that works well for my hairstyle, too.

Here are a few examples of big improvements that came from small, simple tests of change.

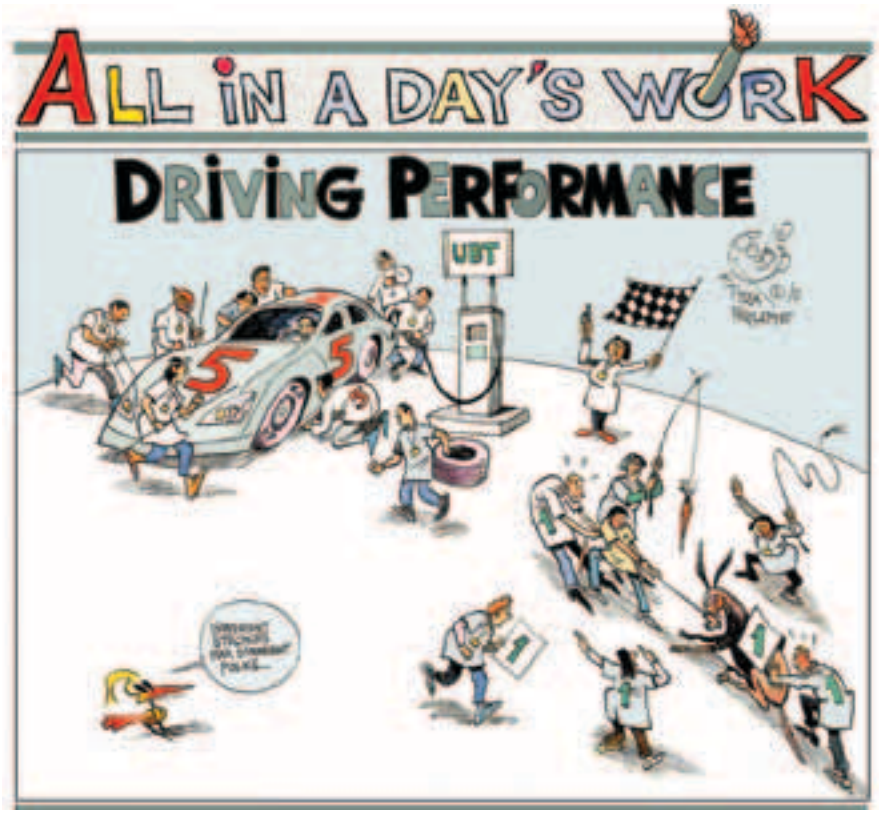
In Fontana, the inpatient physical therapy department purchased inexpensive grease boards of the type found at any office supply store, and posted them in patients' rooms to improve communication with nurses. The physical therapists needed a reliable way to communicate to nurses the status of a patient's mobility and the type of physical therapy the patient was getting. From that small improvement, the rate of patient information exchanged between physical therapists and nurses increased from less than 50 percent in October 2009 to 68 percent in March 2010.

Let's turn to another Southern California team. When the Internal Medicine team at the Hill Road Medical Office in Ventura wanted to focus on helping patients control hypertension, it turned to something simple: a bright yellow sign. The day-glo sign is posted on the outside of exam rooms to remind physicians and staff members to repeat blood pressure tests on patients who require them. If the first blood pressure reading is high, the second test—which needs to be taken at least two minutes after the initial test—helps accurately diagnose hypertension. Before the yellow sign, patients often left before staff could take the second reading.

Keeping it simple: The engineering team in Fontana found a solution to keep information flowing between shifts: a simple greaseboard where unresolved problems could be logged. Shown here, engineer Daryl Brothers, a member of United Steelworkers Local 7600.

Before the team starting using the signs, the needed second blood pressure checks were done only 26 percent of the time. Within one month of using them, the department was giving the second test 100 percent of the time. (Read more about this team in "The Case for Unit-Based Teams," opposite page.)

A little farther south, at Rancho Bernardo Primary Care in San Diego, no test of change is too small. And more often than not, the tests have met with success.



ELEMENTARY TRICKS

One small test included the use of paper clock faces with moving hands, the kind you would use to teach a child how to tell time. A nurse on the primary care UBT suggested they mount the clocks on the outside of exam room doors to help them cut down on the amount of time a patient waits in an exam room before the physician arrives.

After taking a patient into the room, the medical assistant or licensed vocational nurse marks the time the patient was "roomed" so they can monitor how long a member is left waiting.

"Anything longer than 15 minutes is unacceptable," said Evelyn Bartolome, Rancho Bernardo's medical office administrator.

If a staff member notices a patient has been waiting longer than that, the person alerts the physician.

"I haven't received one complaint since we started these," Bartolome says.

I could go on. But then I'd be guilty of making a simple point complex.

One last thing, though.

The beautiful thing about a small test of change? If it doesn't work, you scrap it and move on to the next little ingenious idea, and you keep trying until something sticks. And before you realize it, your small tests of change will have become stepping-stones, leading you out of a quagmire and closing in on success. $(L+M)^P$

The case for **unit-based teams**

A MODEL FOR FRONTLINE ENGAGEMENT AND PERFORMANCE IMPROVEMENT

Unit-based teams are transforming the KP workplace, step by step—but many physicians wonder just how UBTs can help them get better outcomes for patients, improve their department's operations or enhance the patient care experience. An article in the Summer 2010 edition of *The Permanente Journal*, excerpted here, answers those questions.

'If we want to optimize a system, it's going to be around teams and teamwork.'

—Donald Berwick, MD
appointed by President Obama to head the Centers for Medicare and Medicaid Services

ARTICLE BY

Paul M. Cohen, Mark Ptaskiewicz, MD, and Debra Mipos

An Internal Medicine team in Ohio improved its workflow and increased from 62 percent to 74 percent the number of diabetes patients with cholesterol levels under control—surpassing the region's goal—even while coping with a staff shortage.

A medical/surgical unit at Fontana Medical Center, in Southern California, went 23 consecutive months without an incidence of hospital-acquired pressure ulcers—after previously experiencing seven to 10 cases a year.

Colorado's regional laboratory improved the accuracy of its transfer and tracking records from 90 percent to 98 percent, significantly reducing rework and speeding turnaround times for patients' lab results.

These outcomes, and hundreds of others across Kaiser Permanente, were the result of performance improvement projects undertaken by unit-based teams (UBTs)—Kaiser Permanente's strategy for frontline engagement and collaboration.

Physician involvement in UBTs to date has varied, and generally remains limited. However, based on evidence from across Kaiser Permanente, we believe unit-based teams can help physicians achieve their clinical goals and improve their efficiency—and deserve their broader involvement.

HOW UBTS WORK

Teams identify performance gaps and opportunities within their purview—issues they can address in the course of the day-to-day work, such as workflow or process improvement. By focusing on clear, agreed-upon goals, UBTs encourage greater accountability and allow team members to work up to their scope of practice or job description. Achieving agreed-upon goals, in turn, promotes continuous learning, productive interaction and the capacity to lead further meaningful change.

As a strategy for process and quality improvement, UBTs draw on the study of "clinical microsystems" by Dartmouth-Hitchcock Medical Center and the Institute for Healthcare Improvement (IHI).

"If we want to optimize a system, it's going to be around teams and teamwork, and it's going to cut across hierarchies and professional norms," says Donald Berwick, MD, former president and CEO of IHI and now the head of the federal Centers for Medicare and Medicaid Services. "Unit-based teams and much better relationships between those who organize systems and those who work in the systems are going to be essential."

FOUR KINDS OF BENEFITS

The focused nature of UBT activities translates to four broad benefits for physicians and patients:

- **Clinical benefits:** Saving lives and improving health.
- **Operational benefits:** Using resources wisely and improving efficiency.
- **Member/patient benefits:** Giving a great patient care experience.
- **Physician/team benefits:** Improving team performance and work life.

The example below, of a positive clinical outcome in one unit, shows how UBTs use practical, frontline perspective to solve problems.

SIMPLE SOLUTIONS GET RESULTS

The Internal Medicine department at Hill Road Medical Offices in Ventura (Southern California) faced a practical challenge: Patients with an initial elevated blood pressure reading needed to be retested after waiting at least two minutes—but they often left the office before the staff could do a second test. In fact, the staff was doing needed second checks only 26 percent of the time as of March 2008.

The team's simple solution: A bright yellow sign reading, "Caution: Second blood pressure reading is required on this patient," which employees hang on the exam room door so the physician and staff know to do the test.

"The teams come up with good ideas about workflow because these are the folks in the trenches and they see the headaches," says Prakash Patel, MD. "They share ideas and work out processes that help."

In just one month, the department's score on giving second blood pressure tests was 100 percent. Its score on the regional clinical goal of hypertension control went from 76 percent in August 2008 to 79.8 percent in May 2009, just below the regional goal of 80.1 percent.

"I strongly encourage all chiefs of service to champion the unit-based team in their department by either active participation or as a physician adviser, particularly regarding quality, service and access initiatives," says Virginia L. Ambrosini, MD, assistant executive medical director, Permanente Human Resources.

UBTs are taking hold at the right moment for Kaiser Permanente. At a time when health care providers are under pressure to contain costs, maintain quality and improve service, UBTs have the problem-solving tools to address those issues.

Read the full article, including principles of employee engagement and tips for selecting a performance improvement project, at http://tiny.cc/fy848. (L+M)P

Welcome to the New LMP WEBSITE

The Multimedia Resource Center for Your UBT Needs

1 UNIT-BASED TEAMS

You've got a team, now what? Jump to this page for all your UBT needs, and watch your team score.

The UBT section is your entry point for everything UBT- and performance improvement-related. The section features tips, tools and stories on everything from Starting and Running a UBT to Sustaining Performance Improvement.

2 YOUR ROLE

One size doesn't fit all. Whether you're a manager, a union member or a physician—get information for your role in working in partnership.

This section makes it easy to find tips, tools and firsthand narratives that are most applicable to your role and responsibilities in leading performance improvement.

3 STORIES & VIDEOS

Sure, you've got the tools to work on an issue, but how do they *really* work in practice?

This section features stories and videos that share your colleagues' firsthand experience. Learn how other teams worked through a small test of change or how they tweaked a successful practice to fit their team's particular needs.

4 TOOL LIBRARY

Snap on your tool belt and grab what you need—and only what you need.

From checklists to worksheets, posters to PowerPoints, the Tool Library is your one-stop location for the nuts and bolts you need to do your work. You will find a plethora of how-to tools broken out by role, key topics such as affordability or service, and more.

5 CONTRACTS

Be clear about your agreement.

The latest national contract and all local contracts are located in one convenient place for quick and easy reference.

Find it on:

www.LMPartnership.org

(L+M)P The Power of Partnership

FOLD AND TEAR ALONG DOTTED LINE