LABOR MANAGEMENT PARTNERSHIP

THE PATH TO PERFORMANCE:

A Study of High-Performing Unit-Based Teams at Kaiser Permanente

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EXECUTIVE SUMMARY

The 2005 National Agreement between Kaiser Permanente and the Coalition of Kaiser Permanente Unions (CKPU) committed Kaiser Permanente to introduce labor-management unit-based teams (UBTs) in all natural work units by 2010. This Agreement, which deepened and strengthened in multiple ways the Labor Management Partnership first initiated in 1997, described UBTs as the "operating strategy" of Kaiser Permanente and the way it would achieve the goals of the Partnership.

The 2010 National Agreement negotiated by the parties builds on this work by committing the organization to double the number of "high-performing" UBTs in 2011 and increase the number still further in 2012 and 2013. The agreement specifies criteria for high-performing teams and outlines a clear development path for them.

This is an opportune moment for Kaiser Permanente to develop a better understanding of what enables high-performing teams and whether and how teams are contributing to deeper cultural and organizational change. This research focuses on teams identified within their region as "high-performing." In particular, we focused on teams with a history of poor to mediocre performance who had experienced substantial improvements since the implementation of UBTs. These UBTs were assessed via observation and interviews conducted with both individuals and groups.

Understanding Unit-Based Teams

The 2005 National Agreement envisions teams as natural workgroups of physicians, managers and frontline employees who work collaboratively to solve problems and improve performance. Within that high-level definition, however, we found much diversity among teams in terms of their structure, membership and approach to setting goals:

- **Large teams require different structures:** Large departments or units face unique challenges in implementing the UBT concept. We encountered UBTs that faced these challenges by establishing representative structures or developing sub-teams in order to involve more employees in the work.
- **Shared goals can unite teams with diverse memberships.** The social ties of profession or job classification are often helpful in facilitating teamwork. Most teams, however, include a diversity of job classifications. We found that a focus on shared goals helped bring these more diverse groups together.
- **Teams need flexibility and guidance when setting goals.** Regions that gave teams complete freedom in setting goals found that teams struggled to do this. Most regions have moved toward systems that give teams more concrete guidance while allowing them to choose goals that reflect local operational challenges.

Characteristics of High-Performing UBTs

A specific objective of this research project was to identify characteristics of high-performing teams. We have divided those factors into five broad categories: 1) leadership; 2) line of sight; 3) team cohesion; 4) processes and methods; and 5) infrastructure and support. Some

EXECUTIVE SUMMARY

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success factors—physician involvement, strong labor and management co-leads, etc.—have been identified in previous studies. In what follows, we focus on additional factors that have emerged from this study:

1. Leadership: Strong leadership on both the labor and management side is crucial for team success. Key aspects of strong leadership included a strong commitment to partnership from both labor and management, openness to feedback from the entire team and a willingness of managers to embrace more of a "coaching" style of management. Two factors that were identified as particularly important were:

- **Transparency of Information:** The sharing of performance information—including data on financial performance—builds trust between labor and management. Team members were able to see firsthand how staffing, attendance, workplace safety, etc., affect the budget.
- **Joint Leadership:** On most of the high-performing teams we studied, the labor leads—who were generally selected by the unionized employees—took on a very strong leadership role. For example, both parties were equally capable of running team meetings.

2. Line of Sight: A second key success factor for high-performing UBTs is the development of a clear line of sight between the actions of the teams and KP's strategic goals. As a member of one team put it, "now we know not just what to do, but why we are doing it." Teams employed a number of tools to make this happen, including:

- **Review Metrics and Make Them "User-Friendly":** A key challenge for teams is to make performance metrics understandable and easily accessible. Most team members we talked to reported that efforts to make data more user-friendly and share it more widely were new with the establishment of UBTs.
- **Include Budget and Expenditure Trends in Data Review:** Employees responded very positively to the willingness of managers to share information on the department's budget and expense trends. This helped build a sense of collective responsibility for financial performance.

3. Team Cohesion: Successful teams *feel* like teams. In many of the teams we studied, this was the result of specific actions aimed at building team cohesion, such as including physicians as team members, having a safe environment to voice concerns and holding each other accountable for performance. Some particularly important factors include:

- **Diverse Means of Communications.** The high-performing teams we studied communicate via several different methods so that all members of the department have a shared understanding of the work of the team. Key strategies included having regular team meetings or huddles, posting minutes or announcements around the worksite and using email.
- **Meetings Matter.** While appreciating the challenges of taking employees away from their work, most team members believe that some kind of regular face-to-face meeting is vital in building team cohesion and facilitating communication.

EXECUTIVE SUMMARY

4. Processes and Methods: High-performing teams have used structured approaches to performance improvement, particularly the techniques that have been embedded in the unit-based team training programs. Two key tools in widespread use include:

- **Rapid Improvement Model (RIM):** All of the successful teams we studied were using RIM or a similar version of the Plan-Do-Study-Act (PDSA) approach to performance improvement.
- **Huddles:** Most of the high-performing teams we studied were making use of "huddles," i.e. short meetings without formal agendas. Huddles are a particularly effective way to conduct team business without disrupting work flows in environments that have to run 24/7.

5. Infrastructure and Support: While the success of a unit-based team depends on many factors under its control, facility and regional leadership also have an important role to play in providing the necessary infrastructure and support:

- **The Need for Training:** Training—including adequate time for training—was identified as important, although teams are exploring alternatives to "classroom" training to minimize the impact on operations. Team members felt that training provided the team with a shared language and set of expectations.
- **The Importance of Sponsorship:** We found that consistent, aligned, and visible sponsorship is necessary for building successful relationships with UBTs. Sponsors support the work of the UBT, remove barriers when necessary, coach and mentor co-leads, and provide linkages to other resources that are necessary for the team's success.

As a final point, a theme running through all these findings is the degree of flexibility, particularly in structures, processes and methods, shown by these successful teams. While the inclination in many labor-management partnerships in the past has been to create rigid requirements for how frontline committees function, given the variety of jobs and diverse types of work settings within the Kaiser community, it makes sense that offering teams the flexibility to function in ways that meet their particular needs would result in greater team success.

INTRODUCTION

The 2005 National Agreement between Kaiser Permanente and the Coalition of Kaiser Permanente Unions committed Kaiser Permanente to introduce labor-management unit-based teams (UBTs) in all natural work units by 2010. This Agreement, which deepened and strengthened in multiple ways the Labor Management Partnership first initiated in 1997, described UBTs as the "operating strategy" of Kaiser Permanente and the way it would achieve the goals of the Partnership.

The 2010 National Agreement builds on this work by committing the organization to double the number of "high performing" UBTs in 2011 and increase the number still further in 2012 and 2013. The agreement specifies criteria for high-performing teams and outlines a clear development path for them.

This is an opportune moment for Kaiser Permanente to develop a better understanding of what enables high-performing teams and whether and how teams are contributing to deeper cultural and organizational change. It is in this context that the research described below was commissioned. We chose to approach the research by focusing on teams identified within their region as "high-performing." In particular, we focused on teams with a history of poor to mediocre performance who had experienced substantial improvements since the implementation of UBTs. High-performing is defined as sustained improvement to a level of at least above-average performance on two or more outcomes on the Kaiser Permanente Value Compass, one of which must be Best Place to Work.

In other words, while performance on organizational outcomes such as service quality and attendance is necessary, it is not sufficient for a team to be identified as high-performing. We wanted to look at teams that were performing well on those dimensions, while improving the work environment at the same time.[1]

Case studies were conducted on a subset of high-performing teams in different regions to understand how these teams functioned and what factors enabled the teams and their members to change and achieve high performance. Specifically, we aimed to address three overarching research questions:

- What had changed in the way the members of this team work and, in particular, work together?
- What had enabled that change?
- Were there common enablers across the different teams studied? Which of these enablers were unique to the teams studied and which could be replicated with other UBTs?

Research Methods

We began by working with Office of Labor Management Partnership (OLMP) leadership and/or UBT support staff in each region to identify at least one high-performing team in each region to

1 We had also planned to study consistently low-performing teams in each region as a comparison, but that turned out to be difficult to impossible due to confidentiality concerns with these teams.

"We found much diversity among the teams in terms of their structure, membership and approach to setting goals."

study.[2] We confirmed the team's status by reviewing operational performance metrics supplied by the region or the OLMP and metrics related to Best Place to Work from the team's People Pulse scores (Kaiser Permanente's annual assessment of employee engagement). Teams were asked to participate in the study and were free to turn us down as some indeed did.

We identified 16 teams in five regions (Northern California, Southern California, Colorado, Georgia and Ohio) that fit our criteria and were willing to host us for a site visit. At each site visit, we observed a team meeting, huddle and/or the team at work, and we conducted interviews with team leaders and other members of the team. These interviews were conducted individually and in groups. The interview questions focused on:

- the team's motivation to change;
- team composition and structure;
- training;
- team capacity;
- communication;
- sponsorship and support;
- use of measurement;
- performance improvement methods.

We also queried team members about what they believed were the key enablers of their performance.

Key Findings

The research team compiled the results from the interviews and identified a set of findings that apply to UBTs across the KP regions. The next two sections of the report summarize those findings.

The first section focuses on unit-based teams in general and identifies some of their key characteristics as identified by our research. We focus on team size and structure, membership and goal-setting.

The second section focuses specifically on the factors that we found contributed to team success. We have divided those factors into five broad categories:

1) leadership;

2) line of sight;

3) team cohesion;

4) processes and methods;

5) infrastructure and support.

PART I: UNDERSTANDING UNIT-BASED TEAMS

Unit-based teams (UBTs) were established by the 2005 National Agreement between Kaiser Permanente (KP) and the Coalition of Kaiser Permanente Unions. UBTs are natural workgroups of physicians, mangers, and frontline staff who work collaboratively to solve problems, set goals and improve performance. As a strategy for performance improvement, UBTs draw on the study of "clinical microsystems" advanced by organizations like the Institute for Healthcare Improvement and the Dartmouth-Hitchcock Medical Center.

Within that high-level definition, however, we found much diversity among the teams in terms of their structure, membership and approach to setting goals. We studied these attributes to see if they impacted the teams' performance.

Size and Structure: While all UBTs are co-led by a manager and a labor representative, teams were organized into a variety of configurations. UBTs at Kaiser Permanente include both natural work groups and so-called "representative

2 Regional representatives use their own systems or the OLMP's system for ranking UBTs by performance levels and relied on these rankings – which were similar to our criteria to identify teams to study.

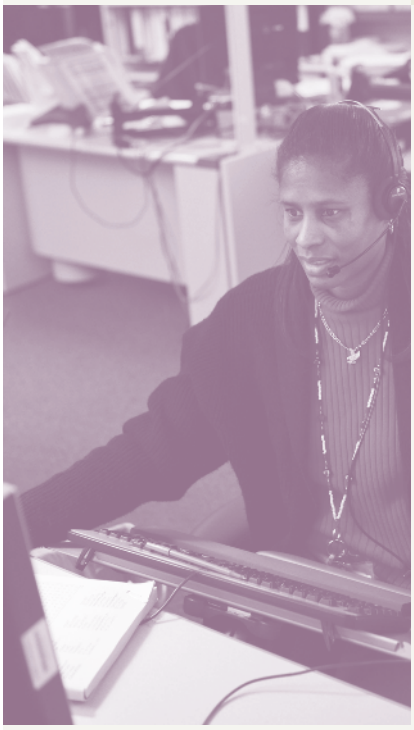
"Membership structures may be flexible as long as the team is focused on shared goals and outcomes."

teams," where a smaller group governs the work of a large team.

Most of the teams we visited were natural work groups, with memberships ranging from seven to 30 employees. Three of the large UBTs we studied, ranging in size from 40 to 120 employees, opted for a representative model. This did not, however, exhaust the diversity in organizational structure among teams. Some other examples follow:

- One outpatient unit of 40 employees, including providers, managers and clerical staff decided at the start of the UBT process to break into four subgroups, three organized around treatment subspecialties and the other around the support staff. The team co-leads plus departmental leadership (about a dozen people in total) met together monthly as a self-titled "sponsor team." Team members reported that most decisions were made at the subgroup level while the sponsor team dealt with problems or impasses from the lower level, or clinic-wide strategic issues.
- In one region, the manager and labor co-lead were responsible for the operation of a clinical specialty over two different locations. Each location had its own unit-based team. Despite their similarities, one unit had significantly better performance. The manager and labor co-lead decided to have the two UBTs meet together as a larger UBT once per month. Once they had done this, the UBT merger and the resulting sharing of information led to the performance of the lower-performing location rising to equal the higher performing one.
- Yet another novel structure we encountered was a regionwide team that brought together RNs from several different clinics but all working on the same chronic medical condition. This team had concluded that it was optimal to alternate weekly meetings between short phone "huddles" and longer face-to-face meetings.
- A cross-regional team that had struggled when it was first launched confronted very novel structural issues – members from outside the KP organizational boundaries. In addition to 35 Kaiser Permanente RNs and physicians, this cross-facility work group also included dozens of non-Kaiser employees from partnering hospitals, nursing homes, and home-based care providers. Both the size and scope had proved to be very challenging and the team, like the large outpatient unit described above, was being divided up into four "sub-UBTs"—one for those in the clinics and nursing homes, another for home-based providers, and one for each of the two contracted hospitals. Each reported to a much smaller representative UBT. This was a very unique form of a UBT.

Membership: The 2005 National Agreement defines a unit-based team as all employees in a natural work setting. What this means in practice is that some UBTs include a wide diversity of job classifications, including physicians, nurses, technicians, medical assistants and clerical workers. Others, however, are more homogenous in their membership. We visited one team that included only nurses focused on a particular clinical issue. Similarly, Environmental Services (EVS) teams tend to include only EVS employees. In both cases, these teams functioned as well if not better than more diverse teams. This suggests that membership structures may be flexible as long as the team is focused on goals and outcomes shared by team members. However, it does appear that the social ties of profession or job classification are helpful in facilitating teamwork.



"Many regions identify broad strategic priorities and specific metrics for teams to achieve."

Setting Goals: Unit-based teams receive training in the Rapid Improvement Model or RIM (see page 12 for additional discussion), a rapid-cycle approach to performance improvement based on the Plan-Do-Study-Act methodology that is in widespread use in quality improvement circles. RIM encourages teams to select goals that are specific, measurable and time-bound.[3]

Many KP regions—such as Northern California, Southern California and Ohio—also provide additional guidance to teams by identifying broad strategic priorities for teams along with specific metrics and targets that the region as a whole is trying to achieve. Teams review these choices and identify which projects they can work on to drive these strategic priorities.

- The Northern California region originally established specific goals around missed meals and breaks, attendance, and workplace safety for teams to work on in 2008-09. They subsequently expanded this list in 2010 to include clinical areas like prevention, chronic disease management and patient safety.

Other KP regions historically have been less directive in their approach. In Georgia, for example, projects were expected to fit into a list of regional priorities, but teams generally had wide latitude to determine projects. We visited one facilitywide UBT that had been instructed to work on workplace safety; the UBTs at the unit levels, however, had discretion as to whether or not to join in that effort.

In Colorado, UBTs evolved from a wide-open approach to setting their goals to a more focused approach. In the beginning, the region allowed teams more discretion or latitude in determining their goals. Because of this, UBTs were choosing goals that were either ill-suited to their day-to-day responsibilities or, sometimes, simply out of their purview. As a result, the region began including orientation to the SMART goal-setting approach in the introductory UBT training.

- One Colorado team we studied initially struggled to come up with a SMART goal, but ultimately landed on one—increasing a clinical goal related to the work of their department. It involved constant study of a specific, measurable ratio, one that the team could increase based on data provided from a patient registry. They could improve the outcomes and bring about some movement in the numbers well within the expected time period. They were able to continually raise the goal over time.

In the next section, we move from a high-level description of how UBTs operate to a consideration of the specific characteristics of high-performing teams.

The table below shows performance goals of eight teams included in this study.

Table:
Selected UBT Performance Measures

- Appointment Access
- Co-Pay collections
- Inpatient Service Quality
- Outpatient Service Quality
- Attendance/Sick Leave Utilization
- Workplace Injuries
- People Pulse/Employee Engagement
- HEDIS (Outpatient Clinical Quality)
- Telephone Response Time
- Specimen Non-Collection Rate
- Specimen Labeling Error

3 The acronym "SMART" is used to help teams remember the type of goals they need to set: Specific, Measurable, Actionable, Realistic and Time-Bound.

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PART II: CHARACTERISTICS OF HIGH-PERFORMING UBTs

In this section, we move from looking at the general characteristics of teams to a consideration of the specific factors that enable high performance. We have divided those factors into five broad categories, including 1) leadership; 2) line of sight; 3) team cohesion; 4) processes and methods; and 5) infrastructure and support.

I. Leadership

High-performing UBTs have strong leadership from both labor and management. The teams that we studied had managers and labor leaders who team members described as "great." The key components of this "great" leadership included:

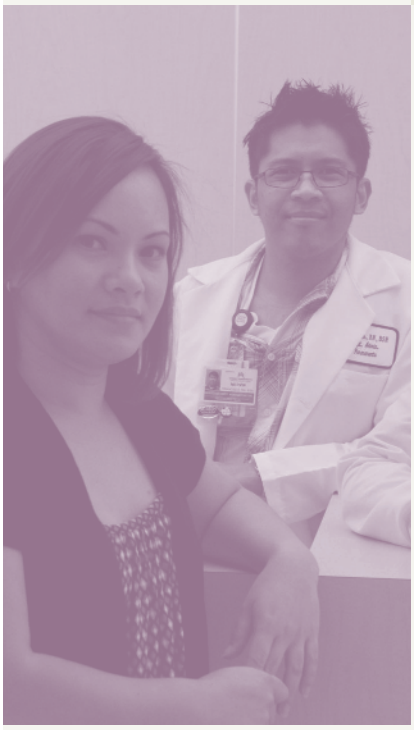
Transparency of Information: Managers and labor leaders of successful UBTs routinely shared important information (e.g., performance and budget data) with team members. In several of the teams we studied, team members spoke about how the sharing of this information—particularly budget data—built trust between labor and management. Team members were able to see firsthand how staffing, attendance, workplace safety, etc., affect the budget.

Commitment to Partnership: Frontline employees responded very positively to managers who clearly respected, valued and listened to employee input. Employees on high-performing teams felt that they were asked for their opinions and that managers took the input seriously. If an employee had an issue, the manager took the time to listen to the employee and jointly come up with a resolution to the problem.

- In one case, to encourage informal, ongoing communication, a manager put the department coffee cart in her office, creating more opportunities for interaction. This innovation ensured the manager and the employees kept up-to-date on the happenings in the department.

Joint Leadership: A major challenge for teams is the development of true joint leadership. On most of the high-performing teams we studied, the labor leads—who were generally selected by the unionized employees on the unit—took on such an authentic leadership role that they became essentially interchangeable with their management counterparts. They were able to develop agendas, facilitate meetings and present data. This required an investment in developing these skills in both leaders, particularly on the labor side. In cases where this did not happen, team meetings were very management-driven and team members often felt they did not have enough input.

"Coaching" versus "Managing": Managers and employees in high-performing teams both reported that the leadership styles of managers changed over time as a result of working in teams. In some cases this was because the introduction of UBTs allowed managers to shift to a style they already preferred. In other cases, however, the manager developed a new style. In either case, this change was critical to the success of many teams. Employees said the managers would work to coach and motivate employees instead of micromanaging them. They trusted employees to do their jobs. Managers of the teams stated that once they were able to change how they managed employees, their job actually became easier. They were able to do this by empowering the employees to make



"Once managers were able to change how they managed employees, their job actually became easier."

decisions about their work, involving them in the operations of the department/unit and listening to employees' suggestions and comments.

II. Line of Sight: Seeing the "Big Picture"

A second key success factor for the high-performing UBTs we studied is the development of a clear "line of sight" between the actions of individuals and teams and KP's strategic goals. Kaiser Permanente and union surveys show that employees, for example, have a strong commitment to providing high quality care and service. Often, however, employees are unsure how their everyday work affects those outcomes.

In the high-performing UBTs we studied, team members described their increased ability to see the connection between their jobs and the overall goals of the organization. As a member of one team put it, "Now we know not just what to do, but why we are doing it." Teams employed a number of tools to make this happen, including:

Regularly Review Performance Metrics: The most important way that high-performing teams improved their line of sight was through a regular review of key performance metrics. The team meetings we observed often started with such a review. In some cases, this review would occur before the start of each shift. Members often groaned if their numbers were down and cheered when they were up. If the numbers were down, teams would talk about why and whether it was necessary to do something to turn it around.

UBTs are working on a broad range of metrics. Most teams we visited were trying to improve their service scores. However, teams were also working on a very wide range of issues, including co-pay collection, workplace safety, clinical measures particular to the group studied (e.g. use of inhaled corticosteroids by asthma patients), use of a Diagnosis Refresh utility, phone call responsiveness, attendance, People Pulse (KP's employee survey) scores and more.

Make Metrics "User-Friendly": A key challenge for teams is to make performance metrics understandable and easily accessible. The UBTs we visited usually tried to present the data in user friendly formats and focused on metrics under fairly direct control of the workgroup. Most team members we talked to reported that this intense focus on data and the user-friendly presentation of the data were new with the establishment of the UBT.

- In one medical center the UBT meeting agendas, meeting notes and next steps were displayed in an employee lounge where all department employees congregated at the beginning of each shift. To further ensure metrics were well communicated, the manager and/or labor leader of the UBT would review important data with the team at the start of each shift, in addition to at team meetings.

Include Budget and Expenditure Trends in Data Review: In our discussions, it was clear that employees responded positively and strongly to the willingness of managers to share information on the department's budget and expenditure trends. This both reflected and contributed to a higher level of trust among the team. Some teams actually received training on how to read their budget, and this clearly helped develop a sense of responsibility for both income and costs.

- One Admissions team came to recognize that collecting co-pays was

"A key challenge for teams is to make performance metrics understandable and easily accessible."

necessary for the economic health of their facility and that a healthy department budget in turn translated into job security. Another UBT learned that using the Diagnosis Refresh utility in the database was necessary for the department/region to receive Medicare reimbursement. One member of this team stated "we never understood how the Diagnosis Refresh utility really impacted the organization's budget—once we did, we could see why we really needed to do this step. If we don't do this, our organization can lose millions of dollars."

Use Systems Thinking: Line of sight is not just understanding broader regional or national goals. It also includes understanding how the work of an individual unit is part of a broader system of care. In the absence of this kind of thinking, teams based primarily around natural work units may miss broader opportunities for system-wide improvement. The most successful teams we studied were interested in how their work and performance were affected by that broader system and were working collaboratively with other departments to achieve common goals.

- One Admitting UBT worked directly with staff from various hospital floors to smooth their interactions. An EVS team worked collaboratively with the inpatient nursing staff to identify ways to reduce workplace injuries. In another case, a team composed of members from multiple departments was tackling the issue of wait times across the entire facility.

Be Careful What You Measure: It is clear that high-performing UBTs respond when they are able to see data and are very engaged in trying to improve performance on their metrics. This growing sophistication with data can be a two-edged sword, however, if teams focus more on manipulating the mechanics of a metric rather than improving actual performance.

- In one case, a department had decided to (and was successful in) increasing its response rates on the service quality survey so it was not disproportionately filled out by "grumpy" people. In another case, the team discussed how to make sure that the patient understood when the work of their particular unit "ended" and the work of another unit began, so that patients weren't confused about to whom to attribute a bad experience.

Focus on the Patient: Our discussion with the teams also revealed that line of sight is not merely about numbers but also about a broader cultural shift that places the patient at the center of team decision making. Many team members spoke about how a focus on the patient helped them move past obstacles and identify improvement opportunities. A clerical employee we interviewed stated: "It's the patient, the patient. You develop a sense of caring. That [patient] could be your mother. We need to practice the Golden Rule." A member of another team asserted "once our team started focusing on the patients, all the work of the team came together. We were able to put aside our differences as team members and focus our work on the patients."

III. Team Cohesion

The employees in the unit-based teams that we studied stressed the connection between high performance and "feeling like a team." In some cases, the department or unit had a strong sense of teamwork prior to the introduction of UBTs. In other cases, though, this was a gradual cultural shift brought about by the

"High-performing UBTs respond when they are able to see data and are very engaged in trying to improve performance."

process of forming themselves into a unit-based team. The UBT structures, training and processes have, at least for the teams we studied, "mobilized" teams for organizational performance. Some of the most important ones identified include:

Diverse Means of Communication: The high-performing teams we studied communicate via several different methods so that all members of the department have a shared understanding of the work of the team. Common practices include the posting of meeting minutes and notes in breakrooms, coffee/snack areas or other areas where employees go on a regular basis (for example, posting of materials in an employee lavatory).

Additionally, teams communicate key information from the UBT to employees during daily or frequent huddles (see Section IV below) in the department. Newsletters were developed by some UBTs and distributed to all employees on a regular basis. Finally, email communication was frequently utilized in areas where all employees had access to email at the worksite. All teams stated that communicating in a way that fit naturally with the work of the department was critical as it ensured that employees understood key messages and created shared language.

Physicians as Team Members: Physician participation in the activities and structures of the Labor Management Partnership has been a challenge from its earliest days. Among the high-performing teams we studied, we found a much higher level of physician (or other provider) participation than was common in the earlier days of the partnership. All the teams we studied that involved direct patient care had active provider involvement. This involvement seems to have improved employee-provider relationships and promoted collaboration for common goals.

Have a Safe Environment: Another attribute of the high-performing teams was a work environment where everyone was able to speak up and had the courage to have difficult conversations. Employees stated they could say what was on their minds without fear of retaliation or retribution. They felt this was crucial to the success of the teams.

Hold Each Other Accountable: Many employees reported that a benefit of the UBT process was a greater sense of collective accountability to each other. This was especially true for attendance. For example, one staff member said, "Our attendance hasn't always been so good. We just work on it. [The manager] has a positive message – why it makes sense. She makes clear why it's important. 'If you're not here, it affects someone else.' She gives the big picture." The teams in another region also reported addressing their relationships with co-workers, which was reflected by an emphasis on team building training. Many workers reported how, with the advent of UBTs, they now "had each other's backs."

Furthermore, we found that this attitude and related behaviors also translated into high performance for patients – workers in different departments were picking up tasks or filling in the gaps that their co-workers didn't attend to, thus making sure that work got done and patients were not left hanging. We heard repeatedly things such as, "We help each other. We'll step in if we see someone is tired. If you can run a test, you just do it, rather than saying that's not my job."

Meetings Matter: A key challenge encountered by many of the teams we

"A benefit of the UBT process was a greater sense of collective accountability."

studied was finding time to meet as a team. While appreciating the challenges of taking employees away from their work, most team members believe that some kind of regular face-to-face meeting is vital in building team cohesion and facilitating communication. Finding adequate time to meet remains an ongoing issue for teams.

- Teams used a variety of creative strategies to make meetings work. Huddles at the beginning of the day or shift are in widespread use among the teams we studied (see Section IV). In ambulatory units, some departments actually did not schedule any patient appointments for their department at certain times so that the team could meet as a large group. In a hospital-based direct care unit, this wasn't an option, but the team met briefly in a room close to the front desk and one team member was designated to watch the desk and step out of the meeting if needed.
- Another ambulatory care group, whose reception desk never closes, conducts what they called "serial meetings" where members who are able to meet fan out and share the information and tentative decisions with co-workers who cannot attend but who can then provide their own input.

Focus on the Work: A key strategy that teams identified to deal with conflict within a department was to focus on the work. While positive interpersonal relationships were a foundation for performance in some teams, other teams had a long history of and even ongoing interpersonal conflicts. For these teams, the UBT made concerted efforts to make all communications center on the patient. By concentrating on the work at hand, interpersonal issues did not get in the way. As one team member stated, "If everyone in the department focuses on the work we are doing, the interpersonal problems between people will be dissipated." A member from a different team made a similar observation: "If there are difficult people [in the department], you have to just shake it off. I've realized, I'm not going anywhere. She's not either. So you have to park your baggage at the door and focus on the goals [of the department]."

IV. PROCESSES AND METHODS

In its training of unit-based teams, Kaiser Permanente has stressed the importance of taking a structured approach to building a sense of teamwork and tackling performance improvement challenges. Some of the specific tools and techniques that teams are taught include, for example, interest-based problem solving and consensus decision making. In our interviews, however, the team members stressed two methods in particular that merit further discussion: the Rapid Improvement Model and huddles.

Rapid Improvement Model (RIM): The Rapid Improvement Model is a version of the Plan-Do-Study-Act approach that is a staple of the quality improvement literature. It stresses the importance of rapid testing of new ideas for improving performance. These ideas then are quickly evaluated and either abandoned, adapted and tested again, or immediately implemented. All of the successful teams we studied were using RIM even if not all team members could recognize or name the specific method.

- One Ambulatory Care team focused on improving the scores that patients gave on a survey for their satisfaction with wait times. The UBT tested a process whereby receptionists began regularly telling patients the length of

"Many team members spoke about how a focus on the patient helped them move past obstacles and identify improvement opportunities."

time they could expect to wait. The team then looked carefully at the trends in the survey of patient satisfaction with wait times and found that after the team implemented the change in communication, patient satisfaction with wait times increased.

- An EVS team working on its service scores experimented with a small subset of the department increasing eye contact with patients and then checked the impact of this change on their scores. They found the patients' satisfaction increased in those areas.
- A lab team used RIM to redesign the process of collecting urine specimens based on the realization that many patients could not leave a urine specimen when they were in the lab. The redesign involved calling patients back at home, sometimes repeatedly, to remind them to return to the lab. In cases where the patient did not return to the lab, they notified the ordering physician so the patient care unit could follow up.

Huddles: Another method/process in widespread use among the teams we studied is the huddle. Huddles are quick meetings without formal agendas and have been found to be effective as a way to conduct team business while operating in environments that need to run 24/7 or without disrupting regular work flows. Huddles are used in addition to formal meetings and trainings, which are essential for all teams.

Huddles were used by most of the unit-based teams we studied. Some teams schedule them regularly in place of longer, formal meetings. In other units, huddles were called spontaneously and could be called by any team member, not just the managers or labor leads of the teams. Most teams would also utilize huddle sheets or would have a daily huddle book that they would use to document and communicate to all department members the important tips or messages of the day. Team members who were not present at the huddles knew to routinely look at the huddle sheets/book throughout their shift so they could be informed of the work of the UBT.

V: INFRASTRUCTURE AND SUPPORT

While the success of a unit-based team depends largely on the team members themselves, our interviews have also identified a number of key external enablers that help teams to succeed. Two important enablers are adequate training for teams and strong sponsorship from higher levels of leadership.

The Need for Training: UBTs are typically launched with some sort of initial training for all team members. In terms of length and content, the training varied by region and sometimes by service areas within regions. The team members we interviewed generally felt strongly that training was important and that it provided their team with a shared language and set of expectations about what it meant to work in partnership.

Nevertheless, training also created certain difficulties for teams. Taking time away from work for structured "classroom" training can create challenges in managing patient care operations. Training can also be a challenge for new hires, as it may not make sense to schedule large-scale classroom trainings for one or two individuals. Some teams have dealt with this issue by employing a "just in time" approach, where co-leads and team members provide orientation to

"Consistent, aligned and visible sponsorship is necessary for building successful relationships with the UBTs."

partnership concepts as the work of the unit is actually being performed.

A related concern was ongoing support for a team after formal training is finished. Team co-leads and members mentioned a number of other enablers needed to obtain the full benefits of training. These included funds, time, coaching and mentoring, and support for meeting facilitation, particularly in the early stages of team development. Many team members commented that without these additional supports, training alone would not help the team be successful. At least one team we observed appeared to suffer from losing its facilitator too soon.

The Importance of Sponsorship: In the case studies, we found that consistent, aligned and visible sponsorship is necessary for building successful relationships with the UBTs. Most high-performing UBTs had leadership and labor sponsors who met with each of their UBTs on a regular basis. These sponsors were designated to be the liaisons between senior leaders (of both KP and labor) and the UBT. Several actually sat on the UBT as members and others came occasionally to meetings. The UBT members commented that this type of structure allowed for greater sharing of information between the leadership teams/labor and the UBTs. The sponsors support the work of the UBT, remove barriers when necessary, coach and mentor the co-leads and team members, and provide linkages to other resources that are necessary for the team's success.

By having a consistent sponsor, the teams reported that they had more direction and felt more aligned with the goals of the region and/or medical center. Also, sponsors reported more knowledge regarding what the UBTs in their region/medical center were accomplishing.

CONCLUSIONS

Many of the findings discussed above are neither new nor surprising. For instance, the importance of participation of physicians, having committed labor and management co-leads, ensuring strong sponsorship and having regular meetings for teams have all been found in previous studies. Factors that are new with the implementation of UBTs and are making a difference are:

- The sharpened line of sight—the systematic integration of UBTs into work of the department and goals of the facility, region and organization. This connection of the work of the team to the larger organizational goals around patient care, service quality and budget discipline/affordability seems to have created the motivation for change to bring the partnership to the front line.
- The systematic use of metrics and organizational support in accessing, analyzing and reporting metrics that enable the line of sight. While some managers had shared team metrics before, UBT implementation brought more consistent, focused and worker-friendly metrics to the team level. This focus on metrics has facilitated data-based discussions between team members led by both management and labor leaders.
- The use of explicit performance improvement models such as RIM/PDSA along with historically well-developed LMP processes like consensus decision making and interest-based problem solving. All teams utilized these models, which helped them significantly improve their performance.
- Other infrastructure support such as training, facilitation, reporting and performance improvement mechanisms.

This additional support has accelerated the success of the UBTs in the different regions. By having these additional support structures, employees in the UBT are able to focus more on the work of the UBT and to obtain successful outcomes.

The other striking finding is the degree of flexibility, particularly in structures, processes and methods, shown by these successful teams. On the flip side, we saw teams failing when structures and processes were too rigid. While the inclination in many labor-management partnerships in the past has been to create rigid requirements for how frontline committees function, given the variety of jobs and diverse types of work settings within the Kaiser Permanente community, it makes sense that offering teams the flexibility to function in ways that meet their particular needs would result in greater team success.

Another aspect of this flexibility is the ways teams and their support structures adapted over time to changing circumstances and learning. For example, several of the teams experimented with different meeting structures and abandoned them when they didn't work. In a sense, this is itself an application of the Plan-Do-Study-Act approach—an application to the team process. Another example is the common use of a facilitator external to the team to help launch the teams. Typically these facilitators drop off if they think they're not needed or have to move on to other teams. But at the same time, we note that a less successful team we observed had suffered from losing its facilitator too soon.

Motivation to change was an area we were interested in assessing because it had been an important part of earlier studies of UBTs. However, it is worth noting that this was not a big issue with these teams. These teams were already focused on change and creating successful outcomes for their departments through the work of the UBT. As one employee pointed out, "I like change because it means we can make things better."