hank

Summer 2012 | Issue 32

FRONTLINE NEWS FOR KP WORKERS, MANAGERS AND PHYSICIANS

WHERE NO ONE HAS GONE BEFORE

INSIDE: NATIONAL AGREEMENT OVERVIEW

ALSO IN THIS ISSUE »

NEW DESIGN! MORE FEATURES!

CONTENTS

From the desk of Henrietta:

What do you think?

You get to a certain age, and it's time for a makeover. Surely you understand.

We heard you whispering. In fact, it inspired us to conduct a statistically valid survey to make sure what we'd overheard was a true reflection of what you thought. Some of it was a pleasant surprise—such praise! But you were blunt, too: Awkward size. Overly long articles. Not enough variety. And so on.

So, here's our equivalent of slimming down and building some muscle. (Amazing what walking a half-hour a day will do!) With our new 'do, you'll find:

- » shorter articles and more of them
- » more tips and tools, information you and your unit-based team can put to immediate use
- » more coverage from all the regions
- » and some fun (see pages 14 and 15!)

While we're on the subject of our virtues: Our paper is certified by the Forest Stewardship Council, ensuring the use of responsible forest management methods that address social, economic and environmental issues.

Why does that matter? Well—working in partnership addresses profound social and economic issues, too. We hope you like our makeover (drop us a line at hank@kp.org), because we want to serve you—the frontline workers, managers and physicians of Kaiser Permanente—well. Because what was achieved this spring in National Bargaining, the subject of this issue's cover story, makes it clear what an extraordinary journey we are on together. hank

+ other features

TEAR-OFF BACK COVER POSTER
We don't need to run marathons to be healthy

WHO'S BEHIND HANK?

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

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 130,000 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.

(L+M)P
The Power of Partnership

AROUND THE REGIONS

COLORADO

Thanks to a diligent chart review process, Colorado's **Medicare Risk Business Services** unit captured an additional $10.3 million last year in Medicare reimbursements unclaimed in 2010. The hospitals Kaiser Permanente contracts with in the region were submitting documentation with incomplete physician signatures, which prevented KP from submitting the bills for reimbursement. The technical error causing the problem was corrected, but the team had to review 26,000 hospital inpatient notes for 2010. The total collected is more than three times what the team predicted when it began correcting the error.

GEORGIA

When staffers at the **Cumberland pharmacy** open bottles of pills to dispense prescriptions, the bottle is supposed to be marked with a big X, a flag for reordering. But often, a pharmacist or pharmacy tech would find only a few pills left in unmarked, open bottles, not enough to fill a patient's prescription. So the team brainstormed ways to ensure the bottles are properly marked, including posted reminders and giving everyone his or her own marker. The number of unmarked bottles fell from 30 to zero the first week; went back up the next week; then dropped back down and stayed down—lowering costs and improving service.

HAWAII

When the **Honolulu clinic's Obstetrics and Gynecology** team members realized patients were waiting six minutes or more for routine injections, they decided to designate one nurse each week as the "shot nurse," whose priority duty is giving shots, and one as a "floor nurse," who helps direct patients to the shot nurse and pitches in when it's busy. Whiteboards let staff know who is filling the roles. The team has dropped member wait times to an average of 3.2 minutes.

Marina Robinson and Evelyn Shimiz, RNs and union co-leads

MID-ATLANTIC STATES

Unit-based team storyboards, a homemade "test of change" video shot by the Radiology UBT on its efforts to boost co-pay collections, and a roomful of enthusiasm and healthy snacks marked the inaugural UBT Expo in the Mid-Atlantic States region. A dozen teams at **Largo Medical Center** in Maryland—from Adult Medicine to Vision Essentials—exhibited projects on service, quality, best workplace and affordability. When attendees weren't networking at the exhibits, they heard formal presentations from teams, who were introduced by their sponsors.

NORTHERN CALIFORNIA

The **Redwood City Medical Center inpatient pharmacy** is celebrating success after sustaining, for more than six months, a dramatic reduction in the rate of medications administered late (a half-hour past their scheduled time) in the medical-surgical wards. Previously, 26 percent were late; now, the range is 12 percent to 15 percent. Working with the med-surg nurse manager, the team began using color-coded bins to distinguish new medications from discontinued ones and delivering medications 15 minutes before the hour in which they are scheduled to be administered. These and other changes have improved communication and give nurses more information about where to retrieve the medications.

NORTHWEST

By focusing on hospital quiet and Nurse Knowledge Exchange, the **Women and Newborn Care arena at Sunnyside Medical Center** has earned recognition as one of the best of its kind throughout Kaiser Permanente. The report rooms—where staff members congregate and talk—have doors that close automatically, and nurses try to respond to all call lights within three dings. "A patient does not belong to one nurse, but the whole department," says Dory Schutte, RN, a member of OFNHP and one of the UBT's co-leads. In addition, Nurse Knowledge Exchange at shift changes and having nurses join physicians and midwives on rounds has improved communication and patient satisfaction. The unit's work has contributed to improving Sunnyside's HCAHPS Overall Hospital rating by 17.5 percent.

Dory Schutte, OFNHP member and team co-lead

OHIO

Giving post-procedure snacks to patients is standard, but Ohio's **Gastroenterology** department realized it was averaging $750 to $800 a month on snacks, well over budget. After Carol Zimmerman became manager, the UBT implemented small but key changes: Eliminating rarely eaten snacks, replacing more expensive items (Oreos) with less expensive choices (graham crackers), and removing temptation by keeping supplies locked out of sight. Zimmerman also began to regularly share the department's budget and costs with staff. The team noticed an impact within two months, with hundreds of dollars saved in short order. Reviewing the budget is now a standing part of team meetings.

Gastroenterology manager Carol Zimmerman

SOUTHERN CALIFORNIA

Faced with teams using linens inappropriately, **Panorama City Medical Center's Materials Management** unit-based team set out to educate other hospital staff about the costs involved—reminding them not to use linens to mop up spills or as makeshift tablecloths and to refrain from overstocking linen in patient rooms. Managers and union leaders worked together to develop a storyboard and presentations and reviewed linen usage and stocking levels with individual departments. The result? The overall costs of linen for Maternal Child Health, one of the first departments targeted, were reduced by 6.8 percent, more than three times the original goal. hank

Partnership's new frontier: Labor and management negotiators used interest-based bargaining to arrive at the 2012 National Agreement. Joan Mah of Northern California (above), an optometrist, senior UBT consultant, and ESC-IFPTE Local 20 steward and vice president, was a first-time observer. Among the 140 union, management and physician negotiators were Dawn Bading (inset, left), vice president of Human Resources in the Georgia region, and Robert Latting, an assistant medical group administrator at Panorama City Medical Center in Southern California (inset, right).

WHERE NO ONE HAS GONE BEFORE

How interest-based bargaining and our new National Agreement set us apart from the crowd

Article by:

MAUREEN ANDERSON and PAUL COHEN

Many of the several hundred health care workers who gathered at the Manhattan Beach Marriott on May 10 are used to working through the night—it goes with their jobs. But they aren't used to waiting. By midnight, some were napping on the couches in the lobby. Others milled about in small groups, talking quietly. And some retired to their rooms and asked friends to call them if and when anything happened.

Finally, around 2 a.m., the news came: A subgroup had ironed out the final details. By 3 a.m., the hotel's central ballroom was filled with cheering, hugging workers—and supervisors, middle managers and senior vice presidents. The 140 management and union negotiators who formed the Common Issues Committee (CIC) gave their unanimous thumbs-up to a new National Agreement that will guide the work of some 130,000 workers, managers and physicians in the nation's largest private health system.

"It was like we had just won the World Series," says Alan Kroll, director of the Clinical Contact Center in Colorado and a first-time member of the CIC. "We'd had our ups and downs as a team, but in the end, we all came through as a team. The energy and camaraderie was tremendous."

'Because of the respect…'

"The energy of the room was not because we liked each other. It was because of the respect that partnership had brought," says Ashwin Deo, an orthopedic technician in Sacramento and SEIU UHW member who served on the CIC.

The agreement, reached in the course of five three-day sessions from March to May, is the largest labor agreement negotiated in the United States this year. Like previous National Agreements, it covers not only wages and benefits but also goals related to service, quality, affordability, workforce and community health, and more. (For highlights of the agreement, please see the 2012 National Agreement Overview insert.)

Yet how the CIC reached the agreement is even more remarkable than the agreement itself. Rather than engage in a power struggle, the negotiators used interest-based bargaining to solve problems. That process allowed it to focus on solutions to the biggest issue facing health care today—that it costs too much, and too few Americans can afford it—while maintaining Kaiser Permanente's industry-leading wages and benefits.

Rather than chopping care or benefits to control costs, says John August, executive director of the

[continues on page 6]

WHERE NO ONE HAS GONE BEFORE

continued from page 5]

Coalition of Kaiser Permanente Unions, the agreement "provides union members with the tools to tackle cost by improving care and efficiency. Improved care and efficiency, delivered by workers at the front line, are the key to extending quality care to every person in our country."

"Our national bargaining is unique," says Dennis Dabney, the senior vice president of National Labor Relations and the lead management negotiator. "There is not only a group of labor negotiators at the table, but a broad cross-section of our employees providing recommendations on how to better deliver high-quality, affordable care and ensure Kaiser Permanente is a great place to work well into the future."

Moreover, the outcome is a testament to the interest-based approach to partnership, not just interest-based bargaining.

"As our facilitators told us, economic issues are tough to resolve in interest-based bargaining," says Adam Nemer, care delivery finance officer in the Northwest and a member of the bargaining subgroup that focused on benefits. "In the end, we met both management and labor's key interests. But I suspect that was not just because of what happened at the benefits table. It was also the result of an open and honest dialogue on benefits between senior labor and management leaders over the past few years. It was about trust and transparency. In my view, we didn't reach a solution just because of interest-based bargaining—but we couldn't have gotten there without it."

THE NUMBER OF MANAGEMENT AND UNION NEGOTIATORS WHO FORMED THE COMMON ISSUES COMMITTEE

140

'We didn't reach a solution just because of interest-based bargaining—but we couldn't have gotten there without it.'

—ADAM NEMER, care delivery finance officer, Northwest region

Quality care equals best place to work: John August, executive director of the Coalition of Kaiser Permanente Unions, and Dennis Dabney, KP's senior vice president of Labor Relations, led the negotiations (above left, left to right). Meeting in groups large and small (above right), the Common Issues Committee reached agreement over the course of five three-day sessions from March to May.

Revolutionary healthy workforce plan

As part of the solution to controlling costs, the agreement includes a revolutionary plan to create the healthiest workforce in the health care industry. Beginning in 2013, the agreement will reward the collective workforce achievement of reduced health risk factors, measured by body mass index (BMI), cholesterol levels, blood pressure levels, smoking rates and workplace injury rates.

"Unions and management agreed that health improvement is an essential strategy for reducing chronic conditions—one of the leading drivers of rising, unsustainable cost," says SEIU UHW President Dave Regan. "This is a high-road, long-term strategy for the common good."

Those involved in the process say it's unlikely that the high road would have been taken had these been traditional, adversarial negotiations. As Joan Mah, an optometrist at San Rafael Medical Center in Northern California and a first-time observer representing her ESC-IFPTE Local 20 colleagues, put it: "Traditional bargaining is really about what I want and not about what is right….When you take the time to allow management and labor to surface their interests, it's really looking for a global solution."

"At times it was frustrating, but it was also interesting to see how the interest-based process led us to options we could work with," says Jean Melnikoff, a senior director of human resources for Southern California, one of the management co-chairs of the workforce of the future subgroup.

Opening doors—and minds

Her sentiment was echoed by members of every subgroup. But that is not to say the process is easy.

"When things get difficult, you need to regroup and work your way through it," says Arlene Peasnall, senior vice president of human resources in Southern California. "But you end up with better results and stronger relationships."

"The people who'd done it before said, 'It's OK, it can be done,'" says orthopedic technician Deo. "Don't be afraid of the tension in the room. Don't be afraid of emotions, because that's what gets creativity out….When labor and management are at the table, talking to each other as equals, and the ideas are valued equally—I think that opened a lot of doors. And minds, too." hank

6 tips for successful interest-based problem solving

Article by: MICHAEL HURLEY

Mike Hurley was the education director for the Coalition of Kaiser Permanente Unions for several years, and he and his team designed many of the LMP programs used to support unit-based team education. Since 2006, he has been national coordinator for the Colorado region.

INTEREST vs. POSITION

An Interest	A Position
is a concern, need or goal that a stakeholder has concerning the issue	tells us how the issue might be dealt with
tells us what has to be addressed in order to reach an agreement	identifies one stakeholder's favored solution
tells us why there is an issue	may not reveal the stakeholder's true needs and concerns
can be addressed in more than one way	may not address the needs or concerns of other stakeholders

1. Know why we use interest-based problem solving

Interest-based problem solving is a collaborative approach to solving problems, a process for negotiating differences amicably without giving in. When you're in an ongoing partnership—whether it's a labor-management partnership or, say, a marriage—you likely have multiple objectives you want to satisfy when resolving differences. Those include not only the desire to solve the problem in a way that meets your needs, but also to solve it in a way that doesn't cost too much (in time, money or emotional wear and tear) and that leaves the relationship intact or even improves it. Because down the road, you know you're going to be working together again to solve the next problem that crops up.

2. Understand key terms

Four words are at the heart of the interest-based process. The *issue* is the problem or subject area to be addressed. A *position* is a proposed solution. The *interest* is the underlying need, motivation or concern that may have to be addressed in order to reach a solution; you can tell an interest in part because there is usually more than one way to satisfy it. An *option* is a potential way to address the issue, in whole or in part.

Your position tells us what you want but not necessarily why you want it.

- A spouse wants to put 5 percent of income into a retirement savings account.
- A parent wants a child in bed by 9:30 on a weeknight.
- A union wants a 3 percent across-the-board wage increase in collective bargaining.

Your interests tell us what is important to you.

- A spouse wants enough saved to have a comfortable retirement.
- A parent wants a child to be well rested for school the next day.
- A union rep wants a compensation package for members that aids recruitment and retention.

3. Ask: Is that 'interest' really a position?

What do you do when you've got a position masquerading as an interest? Usually, you can get to the interests that underlie a position if you listen carefully and ask the right questions. Find out the needs and concerns behind the position. Here's an example:

Statement by wife: *"I hate living in Los Angeles. We should move to Oregon."*

Reaction to self: *"Great, here we go again."*

Question to wife: *"Why should we move to Oregon?"*

Answer: *"We're in a rut. We've lived our whole lives here. I'm tired of it."*

Question: *"What else appeals to you about Oregon?"*

Answers: *"The weather is too hot here, and we spend so much time stuck in traffic. We have to do all our exercising here at the gym. Oregon is cooler and there are prettier roads for biking. We can get to the woods and good hiking faster. People are more relaxed there."*

Interests: Change in weather, less traffic, easier access to uncrowded outdoors, less stress.

By starting with a discussion of interests, the parties can talk about what is important to them without staking out what they want the outcome to be. It opens the door to collaborative problem solving, as opposed to competition or compromise.

4. Agree on the information

Find agreement on what data to collect and how to collect it, vet it and report it—or you'll just argue about the data.

5. Make an action plan

Create a plan for turning solutions into reality. Be clear on who's accountable for what. Establish a timeline.

6. Set ground rules

Remember, interest-based processes don't always work. In my experience, they have the best chance for success if the parties agree to:

- Focus on the issue, not personalities.
- Share information fully and early.
- Listen actively.
- Work hard to meet interests, not sell positions.
- Be open to options.
- Look for ways to build trust. hank

MICRO-CLINICS, MACRO-PARTNERSHIP

FACED WITH OPENING FIVE CLINICS IN 11 WEEKS, OHIO PROVES WORKING COLLABORATIVELY AND REACHING CONSENSUS DOESN'T ALWAYS TAKE LONGER

Article by:

CASSANDRA BRAUN

REGION:
Ohio

What works on the micro scale can become sticky at the macro. Take, for instance, partnership.

True partnering and consensus can be difficult to achieve even for the smallest team or department. The challenges multiply at the grander, operational level, where more people are involved and the interests increase in complexity. But that didn't stop Ohio from collaborating successfully when it expanded for the first time in several years and opened a handful of small clinics in late 2011.

From early on, union and management partnered on what the clinics would look like and how they would operate—not only working with architects on the clinics' design, but also figuring out how to staff the new positions.

"I had a physician say to me, 'They aren't really listening to you,'" says Monica Ussai, a licensed practical nurse and OPEIU Local 17 steward who joined Ann Scott, director of primary care services for the region, and Lydia Cook, MD, the assistant medical director for primary care services, in hammering out the details of the clinics' operation. "That may have been true in the past, but not in this case. They actually took my suggestions. I felt heard and really valued.

"I believe we were truly in real partnership."

Breaking new ground

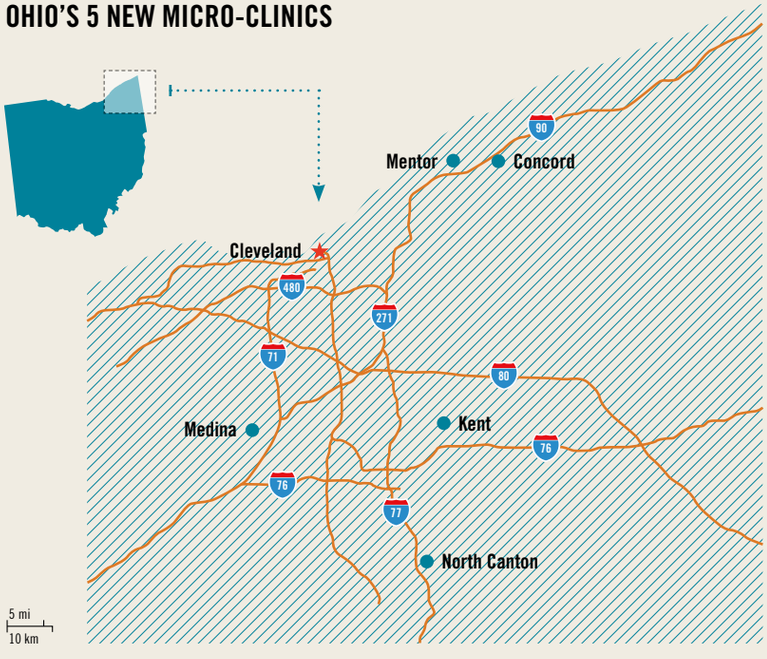
With the Cleveland population moving farther into the suburbs and beyond, the region wanted to provide easier access to Permanente physicians while also facing a Jan. 1, 2012, deadline for reducing use of network (non-Permanente) providers. In response to those competing interests, Ohio decided to open five small "micro-clinics" in outlying areas—and did so with breakneck speed, in just 11 weeks.

"Whether it is delivery system redesign or performance improvement, we make sure our labor partners are at the table," Scott says. "So this was a natural evolution of that….We used the partnership infrastructure that was already in place."

When it came time to turn the idea for the micro-clinics into a reality, the team members who had been developing the vision approached Ussai, who already

[continues on page 10]

OHIO'S 5 NEW MICRO-CLINICS



Breaking new ground: Kaiser Permanente and government officials open the new Medina micro-clinic; shown at top, left to right, are Donald Copeland, MD, president and medical director, Ohio Permanente Medical Group; Stephen Hambley, Medina County commissioner; Dennis Hanwell, Medina's mayor; Michael Todd, chairman, Medina Township Trustees; Tina Granger, member services manager, Greater Medina Chamber of Commerce; and Belva Denmark Tibbs, KP Ohio's vice president of medical operations. Below right, Jen Kader, a licensed practical nurse, cares for a member at the newly opened Medina micro-clinic.

MICRO-CLINICS, MACRO-PARTNERSHIP

◄····· continued from page 8]

sat on several care delivery and workforce planning committees for the region, and asked her to join them.

"They said to me, 'This is different. We need (support staff) to do everything,' " Ussai recalls.

From concept to implementation

The small clinics are modeled on the concept of "medical homes," in which doctors' offices are comfortable places where patients and providers are on a first-name basis. The micro-clinics have micro-staffs, with just one or two care providers and six support staff, while providing the basic services of a typically sized medical office. To do that, medical assistants and licensed practical nurses must do it all—from registering members at the front desk to drawing and processing labs.

'It was about us working together on what was best for the clinics and members.'

—MONICA USSAI, licensed practical nurse, OPEIU Local 17 steward

Macro-partners: Monica Ussai, a licensed practical nurse and OPEIU Local 17 steward, partnered with Ann Scott, Ohio's director of primary care services, and other managers and physicians on opening and staffing the new micro-clinics.

Immediately, Ussai worried that internal staff would be excluded from the new positions because they were unlike any other positions they had had before and, as a result, few if any internal candidates would qualify. In addition, she was concerned about what would happen to an LPN or MA when the Permanente physician he or she supported moved from an existing medical office to one of the new clinics.

"I didn't want them to lose a job because that doctor was being taken away," Ussai says.

So she proposed an unorthodox solution that everyone involved, including the union, agreed to. Traditionally, an employee with the most seniority gets priority for a position. In this case, however, Ussai suggested that first dibs on the new positions be given to the LPN or MA working with the physician being transferred. If that person chose not to transfer with the physician, the opportunity then went to fellow team members. If there were no takers, the position then was opened to general internal and external candidates to apply.

The linchpin to this plan was training. Ussai requested that LPNs and MAs who wanted to move to a micro-clinic receive training in the additional reception and lab duties they would be assuming. Management agreed.

"By doing that, we created the least disruption, by keeping the team intact," Ussai says. "But you have to be really careful with something like this, because you have to be responsible for the end results."

Ussai had to do some convincing of her own union leaders and constituents. "But I felt really strongly about it, that it was the most fair for everyone.... I never made any decision that I wouldn't have wanted made for myself."

The timing imperative

It's no secret that consensus decision making can take longer than the traditional, top-down approach. But in this case, "labor understood the urgency and that allowed us to move quickly," says Dr. Cook.

The region needed to ensure the new clinics and the Permanente providers were ready to meet the needs of the members whose access to outside network providers was being cut back. This meant constructing, supplying, staffing and opening all five clinics between October and December 2011.

"Labor's understanding of the business need was key," says Seona Goerndt, director of diagnostic and support services, who oversaw the opening of the clinics. "They understood the 'why' behind what we're trying to do and embraced change more than I've seen in other things."

Indeed, Ussai says having an understanding behind the decisions was critical in explaining the process to, and gaining buy-in from, employees.

"They knew how things were going to be," she says. "They were happy that they knew their whole lives weren't going to be changed."

All involved agree the strong relationship that already existed between labor and management was the foundation for the success. And despite the varying interests that needed to be considered, the single common interest shared by everyone boiled down to the patient's needs.

"It wasn't about us or them," Ussai says. "It was more about us working together on what was best for the clinics and members."

Ussai, who grew up in a union family, understands how radically different this experience was from traditional management-labor relations.

"My dad used to always tell me that unions were here to protect workers from unfair treatment," she says. "But what we have here (at KP) is totally different. We're there from the beginning, not just for the problems." hank

PHILIP OSTROM

JOB TITLE:
Regional manager of materials and logistics

REGION:
Ohio

Kaiser Permanente Ohio's decision to open five new micro-clinics was a good thing for members. But it meant the possibility of big scheduling changes—and 50,000 more miles a year of driving—for the materials and logistics team, challenging the team to provide the same level of courier services with modest additional resources. It was a chance to work together and test the strength of the partnership. Along the way, Philip Ostrom says, he learned lessons firsthand they don't teach in business school.

Q + A

Have you always subscribed to partnership?

When I started in my position about five years ago, I basically emulated my manager at the time, whose style was, "Here it is; do it." I came in and redesigned all the routes, got rid of redundancies and cut the number of miles driven by 20 percent. There was a definite perception among staff of, "We'll do it, but…" The reception was not positive. Then I returned to school for my MBA. My eyes really opened to partnership when I saw that Kaiser Permanente was doing the same things I was reading about in my textbooks. When you're in one company for a long time and you're in your bubble, it's easy to think, "Oh, what are they coming up with now?" But then you see KP is learning from and setting the pace for U.S. businesses and bringing people with different points of view into decision making.

How did you get the new routes mapped?

When it came time to create courier routes to include the five new clinics, I sat down with our most senior courier and UBT co-lead, William Kelly, and another courier, Doug Sexton, both of OPEIU Local 17, to brainstorm new routes. We also chatted one on one with each staff member to make sure everyone had an opportunity for input. Based on the feedback, the three of us drafted new routes and shifts. We worked together to make the routes efficient, even though it meant a 20 percent annual increase in miles covered, without upsetting employees' work-life balance too much.

Why take time for partnership?

From a management perspective, there is a cost attached to partnership. It requires more time, which is more expensive. Whereas previously it might take 20 minutes to communicate a top-down decision, garnering input from employees requires time. But the investment is worth the return. By working together to come up with the solutions, the couriers feel more invested in and happier with the outcome. From my perspective, it's taken the load off me of trying to come up with the solution myself. hank

'My eyes really opened to partnership when I saw that Kaiser Permanente was doing the same things I was reading about in my textbooks.'

—PHILIP OSTROM

Re-routing: Ostrom (above) and two OPEIU Local 17 members, including union co-lead William Kelly (right), worked together to draft new routes to serve the micro-clinics.

KEY TIP

Opening up communication

Lighten the mood with food. Find reasons to hold potlucks.

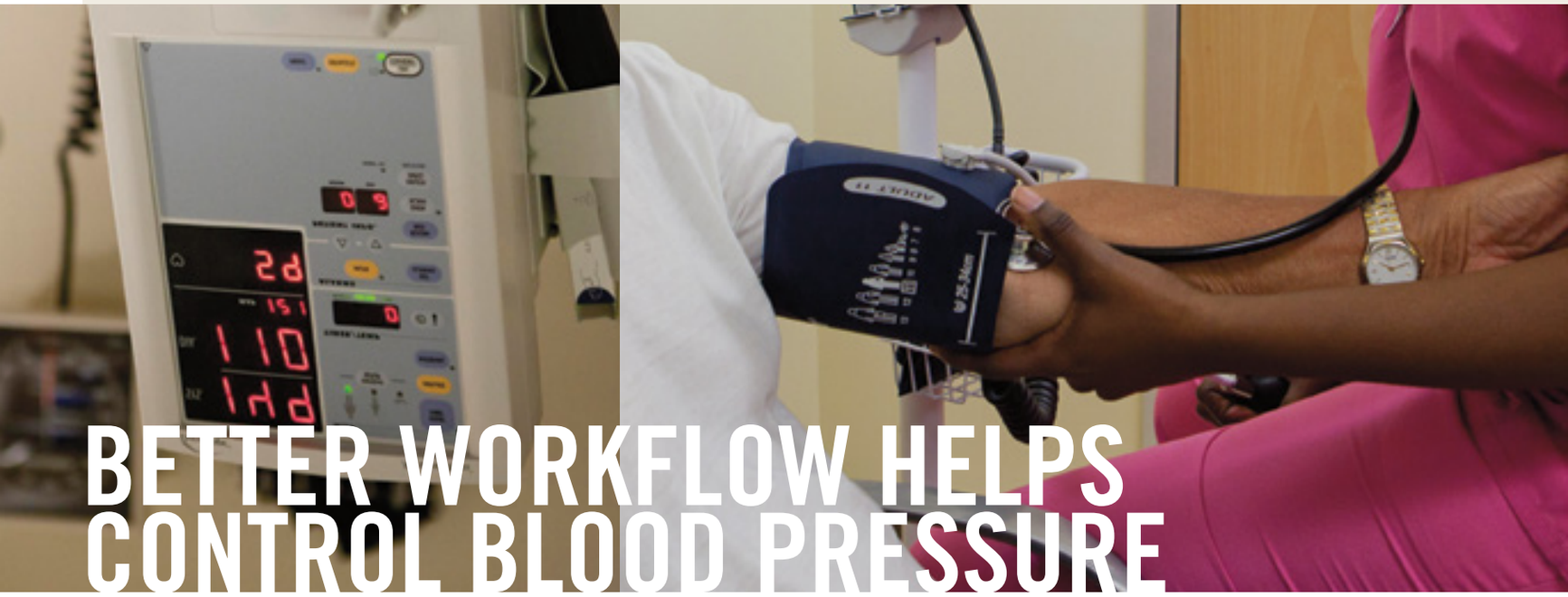
Personalize relationships. Get to know your staff, show an interest in them—something beyond just the task at hand.

Be inclusive. Encourage people to share ideas.

Have difficult conversations. If a worker is unhappy with a decision or if you, as a manager, are unhappy with an employee, don't just leave it unaddressed. Try to explain the issue or decision and why it was made.

PDSA »

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



BETTER WORKFLOW HELPS CONTROL BLOOD PRESSURE

Article by:

ANJETTA McQUEEN

FEATURED DEPARTMENT:
Largo Adult Primary Care
Largo, Md.

REGION:
Mid-Atlantic States

VALUE COMPASS:
Quality

Problem

Too many members with hypertension whose blood pressure was not under control

SMART goal

Increase percentage of hypertensive patients with blood pressure under control from a baseline of 64.7 percent in May 2011 to 72 percent by September 2011

Team co-leads

Cynthia O'Brien, nurse practitioner, UFCW Local 400; Cynthia K. Fields, RN, clinical operations manager

Small tests of change

- Reinforced education of clinical nursing assistants (CNAs), who manage the bulk of the patient blood pressure check schedule.
- Developed specialized scripts for the CNAs, who make outreach calls to patients with hypertension, and for the receptionists, who make reminder calls before the blood pressure check appointments.
- Refined workflow so that CNAs consistently send patients with elevated blood pressure (139/89 or higher) to nurse practitioners for management, and so that primary care physicians refer patients with complex blood pressure medication management for additional consultation, including counsel with pharmacists.

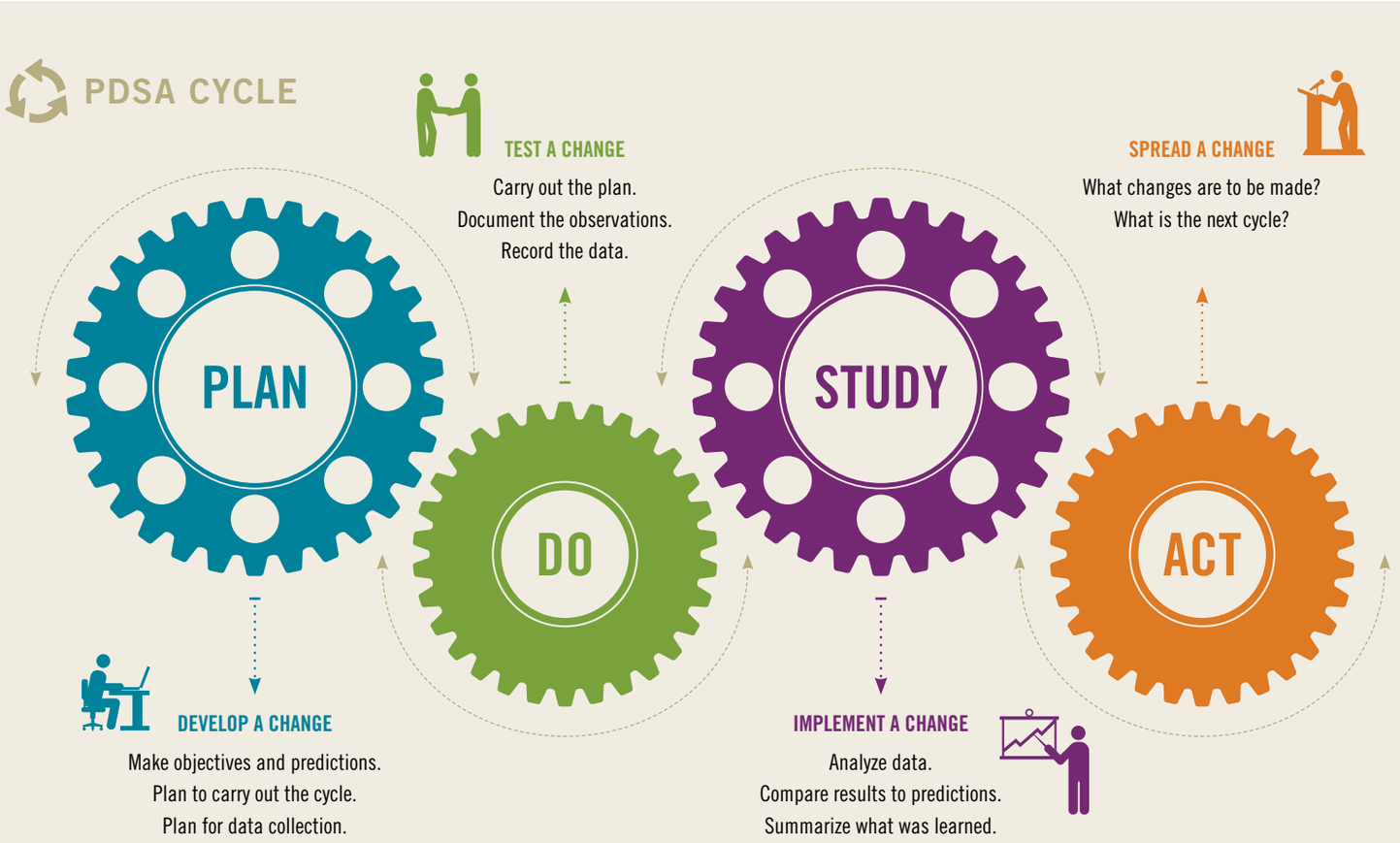
Results

The team exceeded its goal, with 73.6 percent of hypertensive patients with blood pressure under control in September 2011

Next steps

The team has begun spreading successful practices to the specialty departments within the Largo Medical Offices so when patients have appointments there, they will get their blood pressure checked and managed. The Primary Care team has set a new goal of 84 percent of hypertensive patients with blood pressure under control.

"Our approach is to address every elevated blood pressure at the point of contact in all clinical areas," says management co-lead Fields. "The all-hands-on-deck approach is the key to our success."



Biggest challenges

Competing priorities at any given time made some of the staff and providers hesitant to tackle the complex project. Also, the summer months, in which many staff members and providers are on vacation, slowed down efforts to make more outreach calls and reminders.

Side benefit

The team ensured no patient with a repeat high-blood pressure reading left the facility without a plan of care based upon individual needs.

Improved workflow also improved communications and morale. "The providers and staff know that they work hard every day," says O'Brien, the labor co-lead and union shop steward. "But transparent data showing improvements week by week allowed them to see the fruits of their labor."

Background

Last year, the Largo Medical facility had 11,400 members with uncontrolled blood pressure, which represented the highest percentage in the Mid-Atlantic States region. Largo's Adult Primary Care department, with its diverse team of nurses, physicians, certified nursing assistants, nurse practitioners, pharmacists and receptionists, wanted to see who was slipping through the cracks in terms of blood-pressure management—and why.

National studies show that for every 36 patients with hypertension whose blood pressure is brought under control, one life is saved from a heart attack or stroke. The team decided to take action against the care gaps by:

- following up machine blood pressure readings with manual readings
- sending patients with repeat high blood pressure readings to a nurse practitioner or pharmacist for further treatment or counseling
- focusing outreach calls on patients with chronic hypertension

The team made improvements by providing CNAs with tips on better techniques for taking blood pressure to get accurate readings, increasing outreach calls for each receptionist to an average of 20 names each week, and posting weekly certificates acknowledging staff members who were the highest performing or most improved in number of outreach calls and number of blood pressure checks. hank

REMEMBER

Keep these questions in mind when implementing the PDSA cycle.

1. **What are we trying to accomplish?**
2. **How will we know that change is an improvement?**
3. **What changes will help us improve?**

SHARE YOUR BEST PRACTICE

Has your team successfully used the PDSA steps to improve service, quality, affordability or the work environment? Email *Hank* about it at hank@kp.org.

LABOR HISTORY

Longshore start to total health

Article by:

LINCOLN CUSHING
Kaiser Permanente Heritage Resources

In May 1951, Bay Area longshore workers participated in a groundbreaking medical program—the Multiphasic Screening Examination, the first comprehensive health assessment conducted in cooperation with a union.

The trustees of the International Longshore and Warehouse Union–Pacific Maritime Association (ILWU-PMA) Welfare Fund came up with the idea for the tests, thinking it would be a useful corollary to existing medical care by helping detect unsuspected chronic diseases so members could get early and effective treatment. The tests, given in the Local 10 offices, were designed to search out signs of lung cancer, tuberculosis, heart trouble, syphilis, diabetes, anemia, kidney trouble, and sight and hearing defects.

The trustees, together with the Local 10 welfare officer and the ILWU research department, worked out the program with the Permanente Health Plan. ILWU leader Harry Bridges promised results would be confidential and not affect job security, and complete follow-up care was assured as part of health plan coverage.

Recognizing traditional medical services were not well attuned to the health needs of working people, the ILWU newsletter *The Dispatch* noted "Local 10 is going to put five Permanente doctors through a course of indoctrination on the waterfront, so that they will learn first-hand the conditions under which longshoremen work and will be better able to interpret the tests."

More than 65 percent of the local ILWU members participated, and 72 percent of those sought and received medical care for their conditions within four months.

Read the History of Total Health blog at
www.kaiserpermanentehistory.org.

An ILWU Local 10 member gets an electrocardiogram, from "Permanente's First and Largest Coastwise Group," *Planning for Health*, Fall 1951

PUZZLES AND GAMES

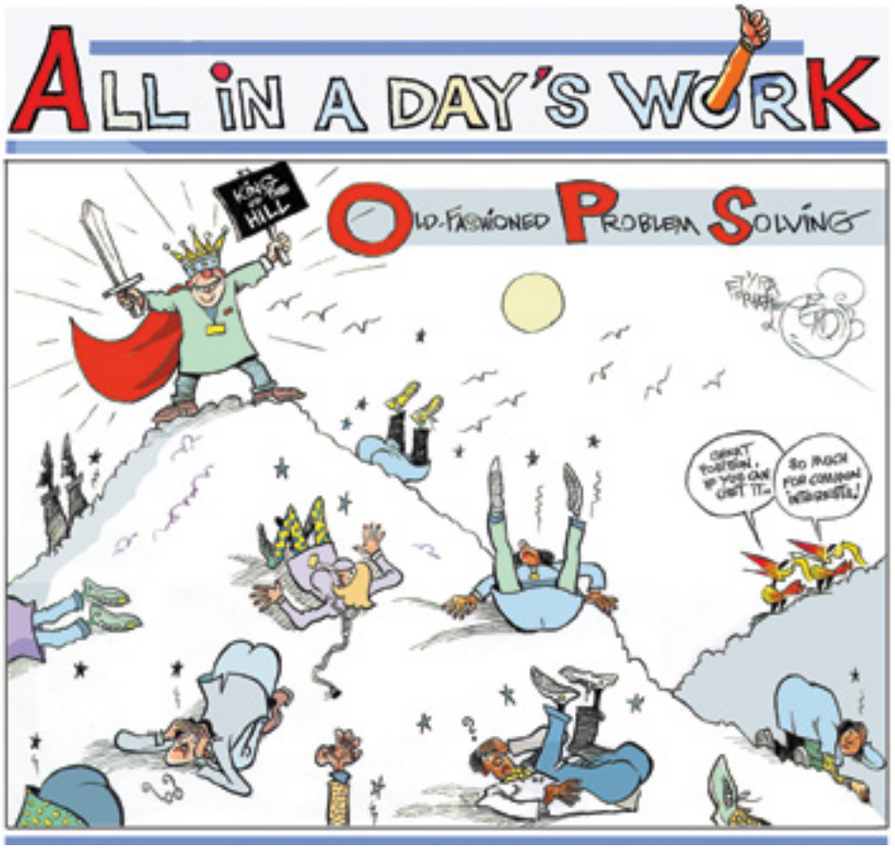
BE AN LMP STAR

Want to be the featured star in the next issue of *Hank*? It's easy—just follow the instructions below for your chance to win a prize and have a shot at LMP fame!

DIRECTIONS:

1. **Correctly complete each puzzle and game:**
   - » Name the individual on the cover "WHO'S THAT PERSON?"
   - » Find our deliberate error "WHERE'S THE MISTAKE?"
   - » Figure out the WORD SCRAMBLE.
   - » Answer the MEDICAL TRIVIA question.
2. **Have fun filling out the HANK LIBS.**
3. **Mail the page to:**
   LMP Communications/Hank,
   1 Kaiser Plaza 24L, Oakland CA 94612
   or scan it in and email it to hank@kp.org.

NOTE: All entries that have the first four puzzles/games correct will proceed to the tie-breaking round: Our panel of LMP judges will vote for the most creative HANK LIBS.



Can you tell the difference between an interest and a position? See page 7 for some tips.

WHO'S THAT PERSON?

In each issue of *Hank*, we will feature someone prominent from Kaiser Permanente on the front cover.

CAN YOU NAME THIS PERSON?

HINT: The "father" of Kaiser Permanente

WHERE'S THE MISTAKE?

In each issue of *Hank*, there will be a purposeful mistake hidden somewhere in the pages. Can you find it?

FOR EXAMPLE:

Name tag on backwards.

YOUR ANSWER FOR THIS ISSUE:

WORD SCRAMBLE

The key to problem solving: Unscramble these nine jumbles and transfer letters to the corresponding numbered squares to get to the final interest-based phrase below.

SUESI	7		32		12									
TIONPO		24	9	27		6								
SEREITTN	29		28	19			4	14						
DENE	8													
LILTOOBANCAOR	2				17		25	16	22				31	
NAOMIOTIVT			21						5	23				
CONECRN		1				11								
SRDADSE				20	10	15	26							
UNLOTSIO	13	30		3	18									

F	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
16	17	18	H	19	20	21	H	22	23	24	25	26	27	28	29	30	31	32

HANK LIBS

Put on your thinking caps

Working at Kaiser Permanente is a bit like a _____ party. Everyone can get
(adjective)
_____ _____ about all the _____ and _____
(adverb) (verb) (adjective) (adjective)
improvements happening, all aimed at making it a _____ place to get care and
(adjective)
the _____ place to work. Sometimes we get _____ by our positions
(adjective) (verb)
and forget to _____ on our common interests. _____ teams have
(verb) (adjective)
overcome these challenges. They use tools to help them work _____ in
(adverb)
partnership using interest-based problem solving. It's all _____ simple when
(adverb)
you _____ about it. Step one: _____ your problem. You wouldn't
(verb) (verb)
believe how often this is where it all starts. Step two: _____ each side's
(verb)
interests, which are _____ needs and concerns. Step three: _____
(adjective) (verb)
together the ones you have in common and come up with options. Final step: Put on
your thinking caps and _____ solutions. Of course, this all takes time,
(verb)
but _____ makes _____!
(noun) (adjective)

MEETING ICEBREAKER

Uncommon denominator: Divide your group into smaller clusters of two to three people per team. Then have the people in each subgroup find three things they have in common. The catch is that the three things cannot be typical or obvious, such as age, sex or hair color. It must be three things that are unusual or not obvious. Give the groups 10 to 15 minutes to work out their shared uncommon things. Then reconvene the larger group and ask each team to share the three things its members have in common.

MEDICAL TRIVIA QUESTION

What was the first stethoscope made of?

a. metal b. rubber c. wood d. glass

Check out this issues's answers to the puzzles and games at **www.LMPartnership.org/puzzles-and-games/answers**.

We don't need to **RUN MARATHONS** to be HEALTHY

Take a first step by taking the **total health assessment**.
It's free, it's confidential, it's online.




Take the total health assessment at **kp.org/hwf**.

(L+M)P
The Power of Partnership

FOLD AND TEAR ALONG DOTTED LINE