Transforming US healthcare through workplace innovation

EUWIN is keen to learn from great examples of workplace innovation worldwide. US healthcare provider Kaiser Permanente is used as a benchmark by many European health services because of its highly integrated and cost-effective patient pathways.

Less well known in Europe is the part that union-management partnership has played in developing the KP model.

We asked John August, until recently Co-Chair of KP’s Labor-Management Partnership, to explain how collective bargaining had led to better quality, cheaper healthcare for patients.

As many of you know, the United States spends nearly 20% of its entire GDP on health care.

There are some who say that this is not a bad thing; that there must be a sector of the economy that outspends the others, so why not healthcare? It creates jobs. It fuels economic growth. So why is this a problem? There are still others who ask, what should be the right amount of spending?

I suggest that these are all the wrong questions.

In fact, these types of questions remind me of a joke I was once told: about the alien who walked into a US hospital and saw a patient hooked up to several IV tubes. Shocked, the alien asked the guide: “why don’t you disconnect all those tubes from the man in the bed; isn’t that what is making him sick?

Spending 20% of our GDP is not making us a healthier society.

Most of you also know that compared to the rest of the industrialized world, the US spends almost twice as much on health care. What many of you may not know is that according to the
World Health Organization in studies completed in 2000 and 2010, the US ranks 37th of all the nations in the world on key measures of health care outcomes for its population.

We are not getting what we are paying for.

I want to discuss several interconnected ideas:

1. That health care spending in the US is bad for our economy, and that a very large percentage of the spending is wasteful.
2. That substantial waste can be eliminated and performance improvement can be achieved through innovation based on collaborative efforts in the workplaces of health care.
3. That the labor-management partnership at Kaiser Permanente is a successful model which leads in this innovation. I suggest that this success provides a great incentive to broaden the establishment of such partnerships throughout the health care industry and more broadly to other industries.

Why is the amount and nature of our spending on health care bad for our economy?

1. Spending on Medicare and Medicaid is the primary driver of the increasing national debt. Peter Orszag, former director of the Office of Management and Budget, has written that “Rising health-care costs are at the core of the U.S. long-term fiscal imbalance. “At a time when our country is teetering on the edge of a “fiscal cliff,” no challenge in health care is more important than reducing health care spending.
2. In the past decade, health care cost growth has wiped out the hard-won earnings of workers and families (Robert Wood Johnson Foundation).
3. Health care spending crowds out needed spending in other sectors of our economy such as education, and physical infrastructure
4. Though long overdue, with the passage of the Affordable Care Act (ACA), we must now extend health care to millions of our people. With an already unsustainable spending trajectory we do not have the luxury of being able to increase spending to meet this need.

We estimate that 30-50% of our health care spending is wasted.

Writing in Health Affairs five years ago, Dr. John Toussaint MD, CEO of the Thedacare Center for Value in Appleton, WI, wrote that “every year there are 15 million instances of medical harm in the US, including drug errors, infections, and wrong-side surgeries. Throughout the care delivery process, doctors, nurses, and technicians are hamstrung by outmoded, cobbled
together systems that encourage waste and do no favors to the most important figure in medicine: the patient”.

Clearly the US health care system not only costs too much, but through its systemic wastefulness, the result is harm and tragedy. The problems are far more important than economics alone.

The NY Times, the Institute of Medicine and many other highly respected sources all agree that waste in US healthcare is at least $700 billion per year, and likely higher.

The major categories of waste include:

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<th>Category</th>
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<tr>
<td>Unnecessary services</td>
<td>$210 Billion</td>
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<tr>
<td>Unnecessary administrative cost</td>
<td>$190 Billion</td>
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<tr>
<td>Prices that are too high</td>
<td>$105 Billion</td>
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<tr>
<td>Preventative Missed Opportunity</td>
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<tr>
<td>Inefficiency</td>
<td>$130 Billion</td>
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<td>Fraud</td>
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Chronic, mostly preventable conditions dominate our spending.

In his recent book, *Don’t Let Healthcare Bankrupt America*, former Kaiser Permanente Chairman and CEO George Halvorson has written that:

- 25% of health care spending is on acute care;
- 75% is spent on chronic conditions (heart disease, asthma, diabetes, and many cancers) many of which are preventable;
- Diabetes alone accounts for 40% of spending on health care, and 90-95% of diagnosed diabetes is Type2, the type that is preventable.

The Robert Wood Johnson Foundation (RWJ) reports that 20% of Medicare spending is on elderly hospital patients who are re-admitted to hospitals within 30 days of readmission costing $26 billion annually. RWJ further estimates that $17 Billion of this spend is preventable.

Finally 7% of hospital patients acquire a pressure ulcer during a hospital stay; that’s 7% out of 35.1 million hospital discharges in 2010 according to the CDC. Halvorson tells us that the cost of each pressure ulcer is $20,000-$100,000, and on average $40,000.

You do the math.
What to do? On its own the industry has not improved!

- Most processes within health care experience 6,000 to 300,000 defects per million opportunities. This compares to error rates of 230 or fewer per million opportunities for world-class manufacturers and fewer than five errors in every million financial-service transactions.

- The “six-sigma” approach to quality improvement embraced by many leading manufacturers strives for an error rate of no more than 3.4 errors per million opportunities (RWJ Foundation).

- The Health and Human Services Department's 2009 quality report to Congress found “very little progress” on eliminating hospital-acquired infections and called for "urgent attention" to address the shortcomings - first brought to light a decade ago (San Francisco Chronicle, April 14, 2010).

The good news to some extent is that “time is up”. The ACA mandates direct cuts to Medicare spending of 1.1% for the next ten years. These cuts are already sending shock waves through the industry as hospitals and clinics scramble to cut costs. While health systems may find ways to cut costs, the real need is to improve, to create value; this is the only way we can find the path to improved human experience and economic sanity in health care. Remember the largest drivers of waste in the system: inefficiency, missed opportunity for prevention, unnecessary services, and price.

There are models to follow.

For at least the third time in the last ten years, the New York Times (March 20, 2013) and many others have identified Kaiser Permanente as the model for the nation: “When people talk about the future of health care, Kaiser Permanente is often the model they have in mind.”

“Over the course of the last 15 years, they’ve been just going into high gear and doing everything right,” said Dr. Thomas S. Bodenheim, a health policy expert at the University of California, San Francisco who recently chose Kaiser as his own health plan.

In this period of time, KP has gone to the top of the industry in quality and patient experience. Some examples:

- JD Power ranked KP highest member satisfaction of health plans in California, Colorado, Northwest, and Mid-Atlantic States in 2012.
- Medicare issued 5-Star ratings to all KP regions in 2013.
- NCQA ranked KP #1 in 29 measures.
- The Leapfrog group identified 16 of the top 53 hospitals in the US as KP in 2012.
And at the same time, in this same 15 year period, KP and its 100,000 unionized employees of the Coalition of Kaiser Permanente Unions have evolved its Labor-Management Partnership (LMP), which according to Tom Kochan and Bob McKersie of MIT, Adrienne Eaton of Rutgers and Paul Adler of USC is the largest, most complex, and longest lasting labor management partnership in US history. I had the privilege of leading the Union Coalition and serving as the national co-chair of the LMP for more than 7 years from 2006-2013.

The LMP began out of crisis in 1997. Over the course of its first decade it made great progress in establishing labor peace, including no work stoppages to date since that time, and made great progress in key areas including the implementation of KP Health Connect, KP’s world-leading fully integrated electronic medical record system. Additionally, the unions have been able to grow substantially during this period from 56,000 to 100,000 union members, wage increases have outpaced inflation, and fringe benefits have actually been improved. There have been advances in workplace safety, attendance, and successful projects and turnarounds. The parties have also made effective use of its employment and income security agreement which provides for redeployment of redundant or outmoded jobs into new positions without loss of pay during the transition, which in many cases requires training and upgrading of skills. There have been major changes in operations including the consolidation of the enterprises’ call centers, a very difficult process which worked well due to the LMP.
The 2005 National Agreement represented a major turning point as the negotiations of that year focused on performance improvement as a centerpiece of the collective bargaining agreement with the establishment of unit based teams. When I arrived on the scene in April 2006, about six months after the 2005 Agreement had been implemented, the parties were struggling with the steps to be taken to actualize whole systems improvement through the enablement of the entire frontline body of managers, physicians, and employees in 600 facilities and nearly 4,000 teams.

Space does not allow for detail in the evolution of this process. But the implementation of system wide performance was accomplished through mobilization of the entire enterprise on a unit based team (UBT) foundation as the way “KP does business”. Key elements included:

- The joint development of a Case for Change, a film and study guide and a joint commitment designed to mobilize the entire frontline, labor, management, and physicians around a social mission of health care improvement -a mission essential for the nation, essential for KP in its competitive environment, and essential for the LMP, to keep the parties focused on a shared purpose of value creation.

- The joint development of business literacy which assists the frontline’s understanding of the business so that as they engage one another on improvement initiatives, the work is grounded as a value proposition, not just a “get along “ arrangement.

- The Value Compass, heralded as a profoundly direct strategic guide post for everyone in the organization. KP has adopted the Value Compass as part of its strategic plan and it appears as the guiding strategy for the National Agreement (CBA). The Value Compass guides the work for every team, asking that improvements in quality, patient/member satisfaction, affordability, while maintaining the best place to work are seen as a balanced set of outcomes, focused entirely on what is best for and creates more value for the patient.
• In 2010 National Bargaining, the parties added the concept of “high performing teams”. Not satisfied with team formation alone, the parties pushed for a rating system based on well-studied attributes of high performing teams and created the Path to Performance. The parties negotiated terms that required that 80% of all unit based teams would become high performing by 2016, with increasingly higher percentages negotiated in each year of the contract. This concept was extended in the 2012 National Bargaining.

• Investments were made to develop a cadre of over 100 improvement advisors, most of who have been recruited from the frontlines of KP; they have been trained in performance improvement science and through the already established facility based LMP councils in every facility, teams were organized and received guidance, facilitation, and training in performance improvement science through a collaboration between the LMP and KP’s own Performance Improvement Institute.

Before I share the promise of the work of the teams, I want to highlight at least one more outcome of the work for the LMP with its emphasis on high employee involvement in decision-making and collaboration at the front line: high employee engagement.

High employee engagement is a much sought after goal of organizations, more important than ever as health systems struggle to implement wide ranging changes in health care delivery.

At KP, internal and external studies have analyzed results of the internal People Pulse employee survey. The correlations are quite significant, showing that when the conditions are created and met for employees to be involved in problem solving, their engagement scores are higher.

In a recent updated study of the LMP, Tom Kochan of MIT shows the high relationship between high performing teams, employee involvement, and improved outcomes:

• In 2012, the LMP mobilized more than 1500 unit based teams to become high performing, exceeding the target in the CBA.

• High performing teams are shown to have:
  ➢ Higher employee engagement scores than lower performing teams.
  ➢ Higher patient satisfaction scores.
  ➢ Lower central blood line infections.
  ➢ Lower injury rates.
  ➢ Better attendance.

Last year KP was ranked the second best place to work in the US in CareerBliss.

With this brief background in mind, let me share some results and suggestions.
Here are some examples of savings from high performing teams:

- A team at the Skyline Medical Center in Colorado had the worst hypertension control rate in the region. After 10 months of work the team improved its rate by 6%, which means 350 more patients are leading healthier lives. The group expects to save 11 lives and save more than $500,000 by cutting back on ER visits, hospitalizations and skilled nursing visit stays. The key to success, according to Dr. Sean Riley was that an idea was jointly crafted, with a shared understanding of the business as a unit based team”.

- Oncology/Infectious disease unit at the Cumberland Office Building in Atlanta, GA embarked on a plan to improve medication reconciliation. In just 3 months in 2011, the percentage of duplicate medications fell by 15% which translated into $90,000 in savings in hospital admissions.

- Fremont OR reduced cost of surgical packs by $34,000 by streamlining the methods for the system for developing the surgical packs. This initiative was part of a hospital-wide effort for teams to look at their line-item departmental budgets and determine ways to save money.

Through enhanced strategic planning among the leaders of the enterprise and the Unions, I suggest it is possible for the parties to have sustained cost savings as a result of the continued organization of and support for highly engaged, high performing teams. Through concerted attention to problem-solving multiplied by thousands of high performing teams, Kaiser Permanente and its Coalition Unions can achieve unprecedented savings in health care, extending the value of its already industry leading model.

A few observations and conclusions:

- KP has high fixed costs, much higher than its competitors with its 600 modern facilities, its electronic medical records systems, and the best paid workforce in the industry. Yet, KP remains competitive in its markets. KP clearly needs and wants to improve, both as a business strategy, but also to live up to its 70 year history as one of the most progressive social benefit organizations in the nation. As a non-profit enterprise, KP plows more than $1 billion per year into community benefit.

- KP is the largest private sector unionized health care entity in the US. When KP goes to the bargaining table every few years it becomes the largest negotiation in the US. So the burdens and opportunities are many.

- As we think about the hidden costs in health care and the crisis as a people we face as a result of our nearly $1 trillion annual waste of this precious resource, the 180,000 people of KP and the more than 9 million people they serve ought to be a model for the nation in health care delivery and in labor management relations.
The KP/LMP model shows that collective bargaining can serve multiple interests:

- the preservation and growth of great union jobs,
- the preservation and growth of the healthcare model for the nation; and
- improvement outcomes and methods for high quality, great patient experience, and cost reduction.

Since the cost of health care is inextricably linked to the health of the US economy at a time when the nation has declared its intent to provide health care for tens of millions more who have gone without, reducing the cost of health care is a clear social mission, an ethical imperative.

KP and its Unions stand on this platform. It is unique and should be studied, supported, enhanced, and extended.

John August became the Associate Director of Cornell University’s NY State School of Industrial and Labor Relations Healthcare Transformation Project in September of 2013. He served from April 2006 to July 2013 as the Executive Director of the Coalition of Kaiser Permanente Unions and the co-Chair of the Labor-Management Partnership at Kaiser Permanente.

John has served more than 40 years in the labor movement having been a shop steward, organizer and local union President. He has held national positions in organizing and collective bargaining with the Teamsters, AFT, and SEIU.