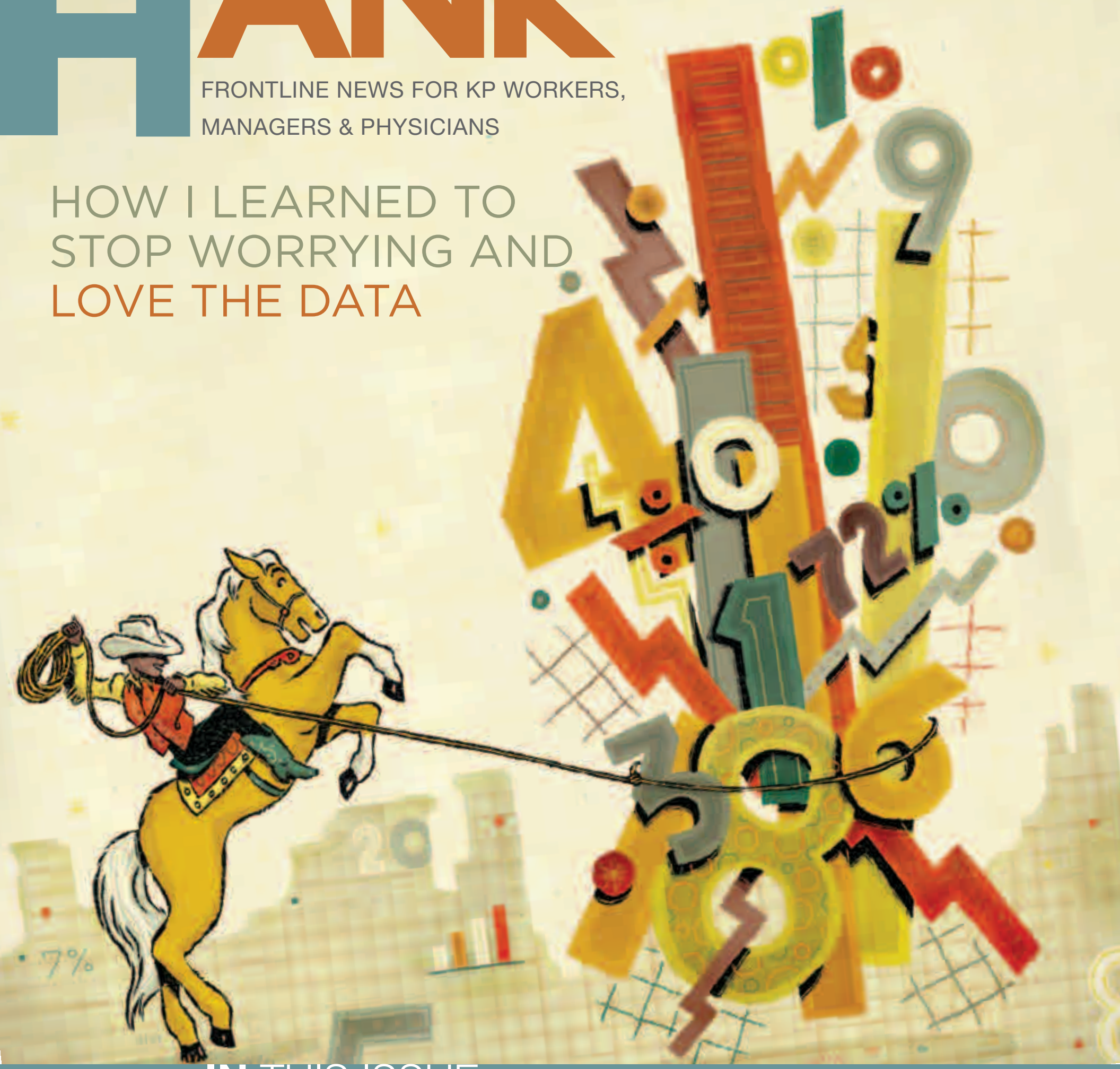
HANK

WINTER 12 | ISSUE No. 30

FRONTLINE NEWS FOR KP WORKERS, MANAGERS & PHYSICIANS

HOW I LEARNED TO STOP WORRYING AND LOVE THE DATA



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Three ways to improve sponsorship and training
Fresno team eliminates customer complaints
How does the Value Compass affect our jobs?

EDITOR'S LETTER: What makes a number good?

9!

It's a great number, the last of the single digits. And it's versatile: Turn it upside-down and you get yourself a 6.

Then there's 8: Two circles carefully stacked one on top of the other. How about 4? Doesn't it remind you of someone balancing in tree pose in yoga? No?

Repeating digits—11, say, or 77—have a different sort of charm, like identical twins. Numbers that you get when you multiply a number by itself, like 49 (7x7) or 81 (9x9), have a mysterious depth to them.

It may seem silly to look at numbers like this, but in fact, some folks are so jumpy around numbers that they start to do something very similar—they treat the number as a thing unto itself and don't stop to put it in context and think about what it means.

"We scored in the 85th percentile!" a med-surg team might trumpet.

"Hey, not bad!" you might respond—our years in school having conditioned us to think 85th percentile sounds about like a B grade.

But what if the 10 other med-surg teams in your area all ranked between the 97th and 99th percentiles? Or what if they all were down in the 40th percentile? In either case, the first team's rank in the 85th percentile looks entirely different.

It also will tell a different story if you know that the previous quarter, the team had ranked in the 83rd percentile or in the 87th. Is the team improving or backsliding?

And what do those numbers say about the care delivered? What will a neurosurgery team's 85th percentile ranking mean to its patients?

"We increased our outreach by 50 percent!" can sound great—but can also be misleading. What was the starting point? It may have been so low that even after increasing by 50 percent, there's still a long way to go to reach the average.

Let's say you're looking at wait times in a pharmacy. If the original wait was five minutes and it's decreased by 50 percent, and is now two and a half minutes, that tells one story. If the original wait was 20 minutes and it's now down to 10, that tells a different story.

And that's the point: Numbers, like words, tell stories. Numbers provide a powerful way to compare and contrast conditions, to show *what's changed* (or changing)—the starting point of a story.

Bombarded as we are by data, it's hard not to wish sometimes for a language that would limit our endless quest to quantify. In some aboriginal societies, after all, there are words that mean "one," "two," "few" and "many"—and that's the end of the line for numbers.

Since we don't have that simplicity—*Hank* hopes you can make good use of this issue's cover story, "How I learned to stop worrying and love the data." (L+M)P

(L+M)P
The Power of Partnership

Published by Kaiser Permanente and the Coalition of Kaiser Permanente Unions

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

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

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

GOLD QUILL AWARD WINNER
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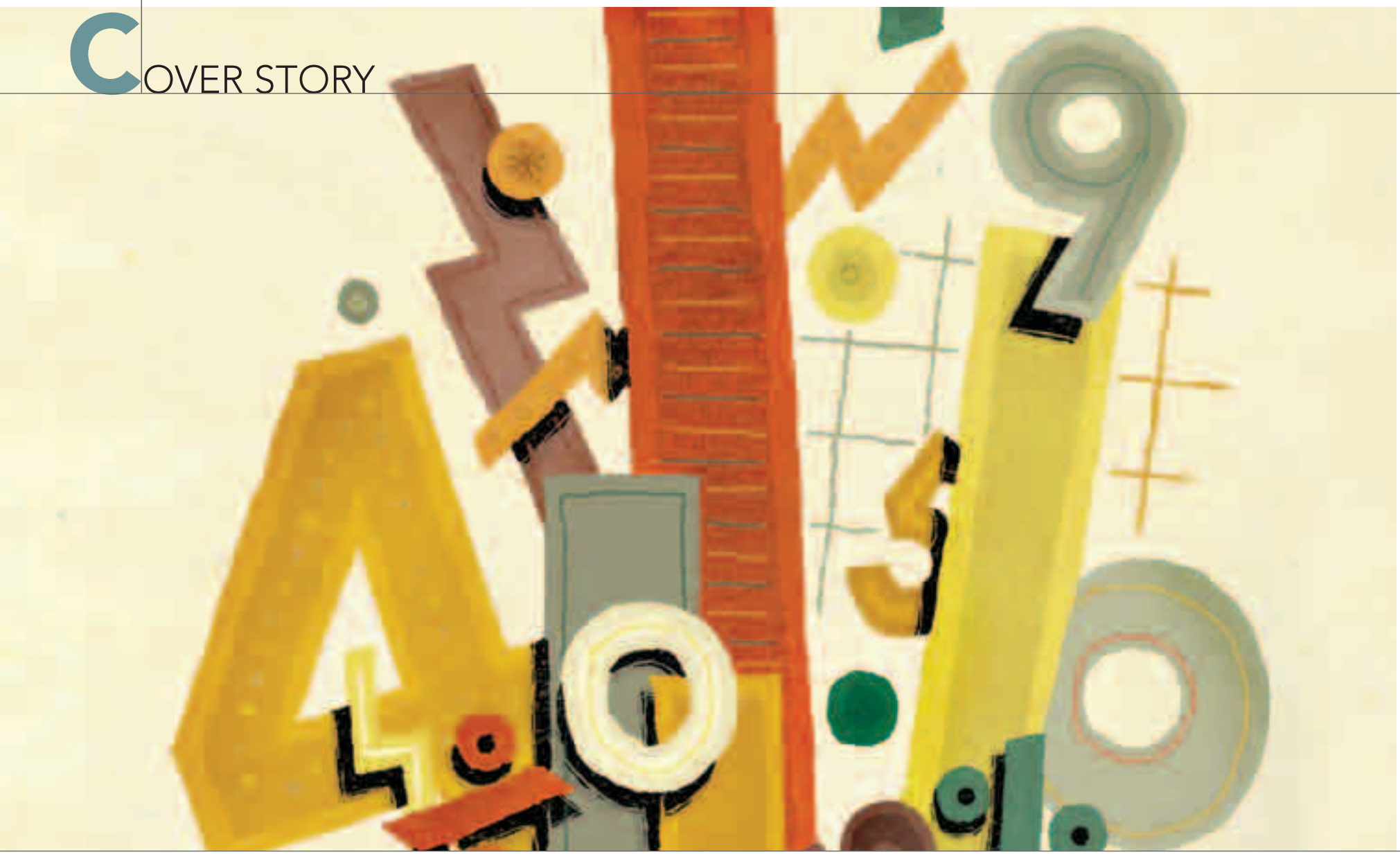
Tell me your story



HOW I LEARNED TO STOP WORRYING AND LOVE THE DATA

For more than a year, the service scores at the Moreno Valley Optometry department zigged and zagged in no discernable pattern. Asked whether receptionists were helpful and courteous, 100 percent of patients answering the Ambulatory Service Questionnaire gave the highest score one month. But two months later, only 78 percent of respondents were that enthusiastic. Two months after that, scores were back up into the 90s.

The huge swings were discovered in May 2011 by Stephanie Valencia, the department's new manager, who excavated two years' worth of data.

"We had never looked at it before," she says. "There was no trend. The scores were inconsistent." Worse, says Valencia, the feedback from the most recent months was headed "on a downhill streak."

Working with labor co-lead Gina Hitt, an optician and a member of Teamsters Local 166, Valencia and the unit-based team gathered information and set a baseline. For two days in September, the medical assistants asked all patients whether they found the receptionists to be helpful and then tallied the results. The team used these to measure the effectiveness of a rapid string of small tests of change. These included adding a smile, positive tone of voice and eye contact on successive days. Each of those days, Hitt and her colleagues asked patients whether their receptionist was courteous and helpful. With each successive effort, the chorus of "yes" got louder and more effusive.

The act of simply examining the service scores seemed to set the team on an upward trajectory: The April 2011 score of 79.55 percent jumped to 89.09 percent in September and then 92.73 percent in October.

"It is so neat to see how involved people are," Valencia says. "Everyone is in sync."

So, that's a happily-ever-after story, right? Once upon a time, there was an optometry team in Southern California that never looked at its service scores. Suddenly, team members learned their scores were inconsistent and heading in the wrong direction. They focused on key data and tried out small tests of change. Their new practices boosted the score. Everyone lived happily ever after.

This happens every day with every UBT throughout all of Kaiser Permanente.

Right?

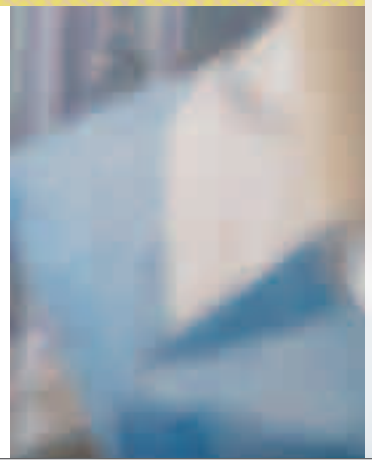
Maybe not.

Some UBTs are adept at using data to guide their attempts to improve performance, whether it be raising service scores, reducing infections, creating a safer workplace or boosting attendance. But for others, fear and anxiety about data and numbers are a significant obstacle on teams' path to high performance. In order to qualify as a Level 4 team on the Path to Performance, the team has to collect its own data and review it to see whether changes are helping improve performance. To ascend to Level 5, teams must be measuring their progress using annotated run charts.

(continues on page 4)

HOW I LEARNED TO STOP WORRYING AND LOVE THE DATA

Smart use of data helps infants and children: Many of Panorama City's unit-based teams are adept at using data to track what's working and what's not in their day-to-day work—and have seen big improvements in service scores. Pictured on these pages: Members of the NICU unit-based team, which has tackled pain management and other issues, include Emma Yabut, RN, a UNAC/UHCP member (this page); David Braun, MD (opposite page); Shukla Sen, department administrator (page 6, left); and charge nurse Lori Speers, RN, a UNAC/UHCP member, with Yabut (page 7, left to right). Maria Teresa Araujo (page 6, right), a member of SEIU UHW, is a member of the medical center's Food Services department, whose UBT worked with Inpatient Pediatrics to make sure kids were getting food that was good for them *and* that they liked.



'We are all data collectors. And every day, we alter our behavior based on data.'

—**Stacy Dietz,** UBT consultant, Southern California

(continued from page 5)

But what if you break out in a cold sweat and experience shortness of breath at the sight of anything vaguely resembling math or numbers? Do you simply resign yourself (and your team) to being roadkill on the Path to Performance?

No. Here are—

HANK'S SEVEN WAYS TO CONQUER YOUR FEAR OF DATA

ONE: Realize you are plenty smart enough.

Kaiser Permanente, like all large health care organizations, collects and stores vast amounts of data in a variety of complex databases and websites. It employs people with a huge variation in their knowledge of and comfort with data. Just because you're not at ease with numbers now doesn't mean you never can be.

Even Bob Lloyd, the executive director of performance improvement at the Institute for Healthcare Improvement, an independent nonprofit in Massachusetts, jokingly refers to statistics as "sadistics."

Luckily, the data you will need to turbocharge your team's efforts to improve performance is probably a lot less complex than you fear (see Four, next page).

"It's not really 'math' with formulas, statistics and calculations," says Michael Mertens, a Kaiser Permanente performance improvement mentor in Southern California. "It's mostly about before and after, addition and subtraction."

TWO: Whether you acknowledge it or not, you collect data every day.

"My role in the tests of change has been soliciting feedback from the patients," says Hitt, the Moreno Valley optician. She didn't need a computer program or spreadsheet. A piece of paper and pencil did the trick.

"We are all data collectors," proclaims Stacy Dietz, the UBT consultant for regional operations in Southern California. "And every day, we alter our behavior based on data." For instance, we ask, "What is the temperature outside?" Then we decide whether to wear a wool turtleneck or tank top. We ask, "What is the length of my commute?" Then we decide whether it makes more sense to drive or take the train.

If you can collect and analyze data to determine your wardrobe, you can also do it to improve the performance of your team.

THREE: **Before diving into the numbers, focus on the 'why.'**

As the new Kaiser Permanente ads challenge viewers, "Find your motivation." For unit-based teams, the Value Compass offers a handy cheat sheet on motivation: The patient is at the center. Every data point on every chart represents the impact—positive or negative—that a Kaiser Permanente team had on a patient.

IHI's Bob Lloyd explains there are three distinct reasons in health care for collecting and examining data:

- For research, such as KP's recent study that found women in their late 60s who break a bone are five times more likely to die within a year than women that age who do not break a bone.
- For judgment, a category that would include the federal government's recent rankings of Medicare insurance plans on quality and service (several KP plans got five out of five stars). This category also includes scores that determine whether or not a medical center or department earns its Performance Sharing Program (PSP) bonus.
- For improvement.

This last is the reason UBTs should be collecting and examining data.

"The purpose of measurement in quality improvement work is for learning, not judgment," Lloyd says.

Data answers questions like, "How are we doing right now?" "Over time, are we getting better? Or getting worse?" "Is our small test of change making a difference? Or not?" In the absence of data, we have a tendency to fall back on relying on guesses, gut instinct, anecdotes—and to blame or give credit to specific individuals, justifiably or not.

"You need data. Otherwise, you don't have any solid information," Hitt says. "You just have word of mouth."

FOUR: **Don't bother getting more data or more complicated data than you actually need...**

The holy grail of data for UBTs is the run chart. Don't let the name throw you. It's simply a chart that tracks some number (say, a service score, or number of last-minute sick calls) over time (day, week, month, quarter).

"The most crucial question to ask is, 'What are the few, vital pieces of information that are important?'" says Dennis Benton, executive director of the Panorama City Medical Center in Southern California. Any graph or data set that requires its intended audience to get special training to read is probably too complex for the task at hand, he says.

"You can do a quick, just-in-time training at a UBT meeting," says Benton. "We do it in leadership rounds. I point to the graphs and talk about them."

FOUR and a HALF: **...but, do get the data often enough to support your improvement efforts.**

For most teams' small tests of change, data that can be collected daily, weekly or—at most—monthly will be most useful. Waiting for quarterly reports is generally not going to cut it. The Moreno Valley Optometry department did not wait for the Ambulatory Service Questionnaire results—which are posted monthly—to come in. It's called the Rapid Improvement Model, folks. Not the Slow-as-Molasses Improvement Model.

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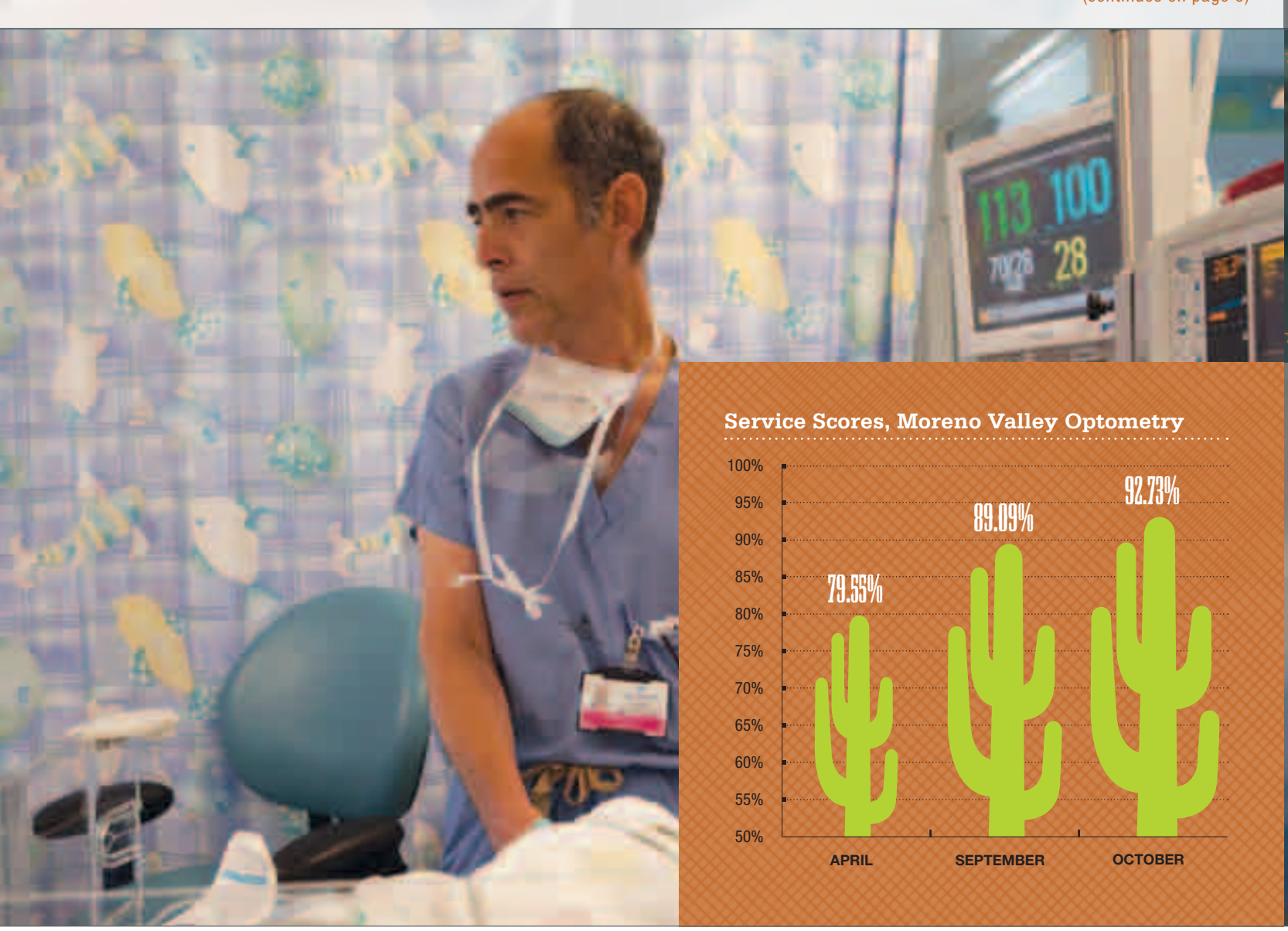
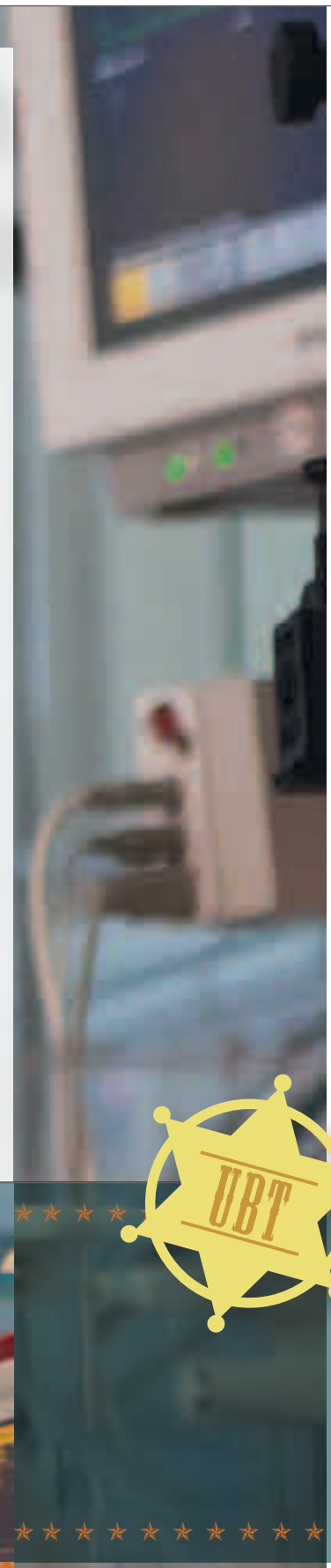
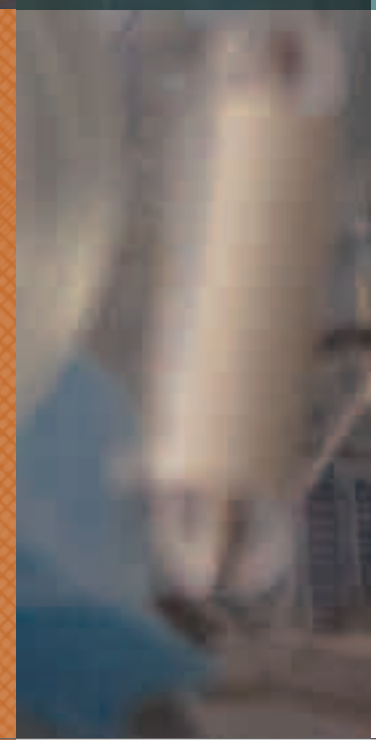
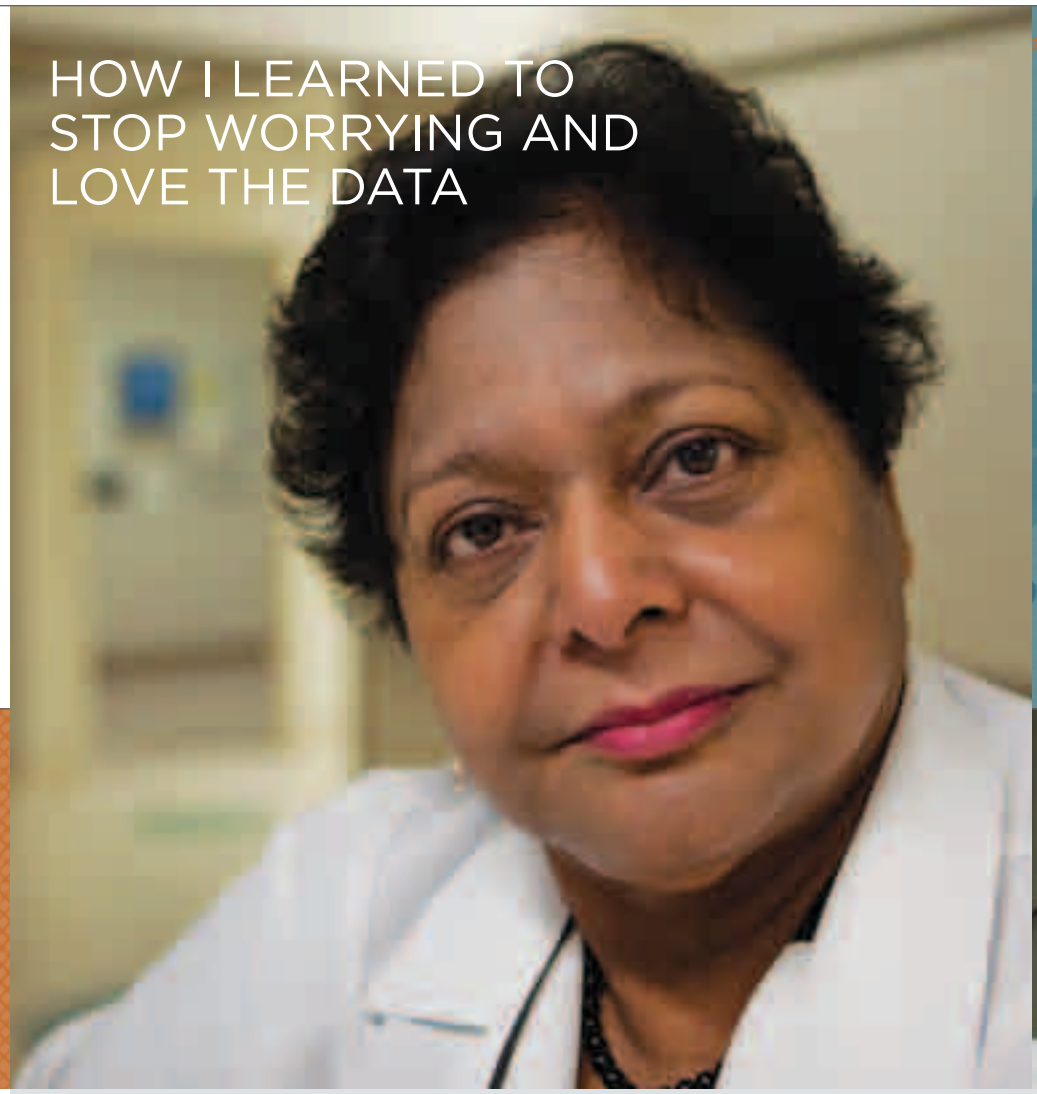






Service Scores, Moreno Valley Optometry



HOW I LEARNED TO STOP WORRYING AND LOVE THE DATA

‘My audience is the UBT. The graphs help UBT members make sense of everything.’

—**Jenny Yang**, receptionist, Moreno Valley Optometry

(continued from page 5)

Bottom line: The data should be useful for the team and be determined by the team.

FIVE: Think art class, not math class.

“I hate numbers,” admits Jenny Yang, a receptionist at the Moreno Valley Optometry department and a member of the UBT’s representative group. When the notion of using service scores to guide improvement first came up, Yang says she told her teammates, “I’m not going to do it. Make someone else do it.”

To help others like Yang, Benton says, when it comes to data, “Make a picture out of it. I am a big believer in graphs. With a graph, you can say, ‘We dipped here. What is the reason? What can we do about it?’ You can look at a trend relative to the goal.”

“Graphs are visual,” Valencia adds. UBT members have a variety of learning styles and preferences: “Everyone learns differently.”

And think in terms of moving video, not still photographs that capture single moments in time. IHI’s Lloyd asks, would nurses measure an ICU patient’s vital signs only when the patient arrived and when she left the unit? Or would they monitor vitals constantly via a telemetry machine? The second option is better, so caregivers can intervene in real time to help the patient’s recovery.

SIX: You didn’t like art class? How about creative writing?

Numbers can tell a story. “There is narrative in data,” says Nancy Duarte, the author of “Slide:ology” and “Resonate,” two popular books about how to give compelling and memorable presentations. “What makes the numbers go up and down? How big are the numbers? How do the numbers contrast with other information?”

Yang agrees. Graphs with data “give you key points, high points and low points and trends,” she says. As a member of the representative UBT, Yang—a member of Steelworkers Local 7600—sees herself as a storyteller: “My audience is the UBT. The graphs help UBT members make sense of everything.”

Hey, if you liked math class, more power to you. “I love math,” says Hitt. “I am a number cruncher. But for me, charts and graphs? Not so much.”

SEVEN: It’s OK to ask for help.

So that graph you pored over in your UBT meeting is still making you break out into a cold sweat?

“It’s OK to find a safe place to say, ‘I don’t get this,’” says UBT consultant Stacy Dietz. That might not be in a big group, but it could be one on one with a trusted peer.

Mertens, the Southern California performance improvement mentor, says the best way to learn to use data is to try it out. At the request of Susie Bulf, a UBT consultant, Mertens led a training for UBT co-leads in Fontana on how to create a run chart. He led an in-class exercise using sample data—and then another exercise where each team used its own data.

“You get over the anxiety by doing it the first time,” Mertens says.

Each KP region boasts a roster of experienced performance improvement mentors who can be reached via the intranet at **http://kpnet.kp.org/qrrm/perf_imp/index.htm**. In addition, most UBT consultants have had some training in performance improvement strategies.

THE KEY TO LIKING DATA

When data starts helping your team do its work better and improve performance—you’ll begin to find satisfaction in using it.

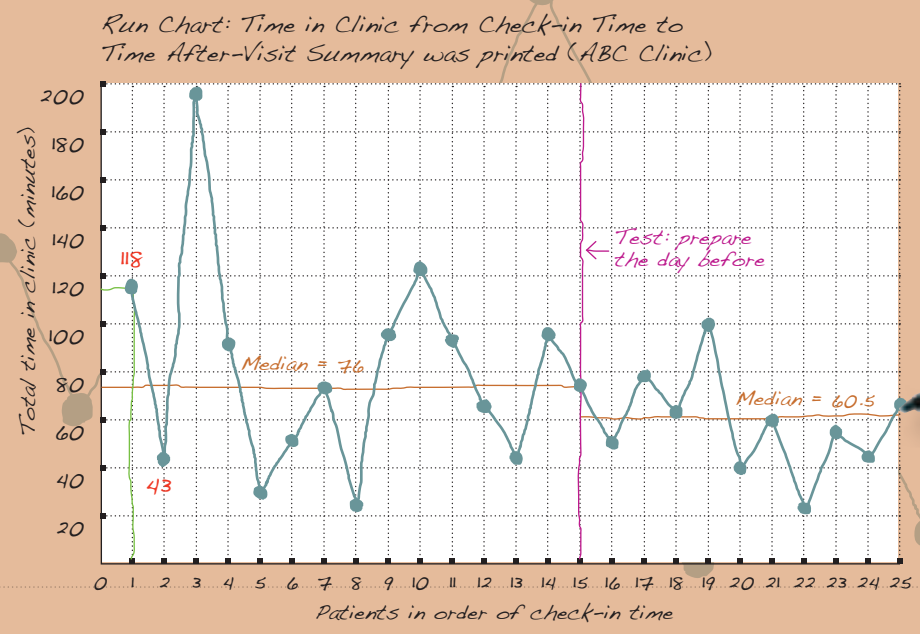
You might even become a fan.

At Panorama City Medical Center, Benton and his staff prepare and email graphs on a regular schedule.

“If we’re a little tardy getting them out, people start calling me and saying, ‘Where are my graphs?’” he says. “We see them plastered on bulletin boards everywhere.” (L+M)[P]

9 STEPS TO CREATE A STORYTELLING RUN CHART

Time in Clinic Data			Date:	
Pt	Check-in	AVS	Time	Min
1	09:44	11:42	1h 58m	118
2	11:14	11:57	43m	43
3	11:34	14:12	2h 38m	198
4	13:25	14:57	1h 32m	92
5	14:28	14:56	28m	28
6	14:44	15:35	51m	51



A RUN CHART TELLS A STORY. It's a visual aid that helps your team see how your small tests of change are working. Those plotted data points aren't dry dots on paper—they're expressing our patients' experience and letting us know how well we're delivering on our mission to provide the best care and service at an affordable price. Follow these steps to create one:

1. Paper, pen, ruler.

Get some paper—make it big, so you can post it on a wall and everyone on the team can see it—a ruler, and a pen or pencil.

2. Line it up.

Draw and label the vertical and horizontal lines. The vertical line is the *y* axis and shows the measure to be tracked (quantity, percent, etc.). The *x* axis is the horizontal line and shows the time interval (day, week, month) for data collection or a sequence (for example, patient 1, patient 2, and so on). Typically, teams will want to collect information by shift, or hourly, daily or weekly.

3. Name it!

Give your chart a title. Begin with "Run chart," then include the measure you're tracking, and a location or other identifying information.

4. Baseline data.

Put your baseline data points on the chart and label them. The data might come from a computer-generated report (HEDIS scores for adolescent immunizations) or it may be information collected by UBT members (how long patients are spending in the clinic). (In the example above, the baseline is the information about the first 15 patients.)

5. Determine the median.

Figure out the median for your baseline data and draw a horizontal line at that value.

The median is the middle number (not the average) in a series of numbers arranged in order of size. If you have an odd number in the series, it's the number in the middle; so, for example, in the series 2, 5, 8, 9, 12, the median is 8. If there's an even number of values in the series, take the two middle values, add them together and divide by two—in the series 2, 5, 10, 15, 17, 23, you'd add 10+15 (the two middle values) to get 25, and divide that by 2 to determine the median is 12.5 (25÷2=12.5).

6. Post the chart.

Choose a spot where the whole team can see it.

7. Keep collecting data and updating the chart.

As the team collects data, get it posted right away—keep the chart up to date. A run chart is a living document, not a finished work of art.

8. Mark it up.

Make a note on the chart—an annotation—when you conduct a small test of change (like the note "Test: prepare the day before" in the illustration above). Watch what happens to your data points after the change to see what effect the change is having. Figure out the median for this new set of data (collected after the change) and draw that new median on the chart.

9. Adapt, adopt, abandon.

If the new median is better than the old median, you may want to adopt the change straightaway. Or you may want to adapt the change to see if you can get even more improvement; in that case, make a new note on the chart about the change and start a new round of observation. Alternatively, the results may show it's time to abandon the change and move on to your next test.

Why is it called a run chart?

A "run" is a string of data points above or below the median. The longer the run, the greater the likelihood what you're observing is a significant effect, not normal variation.

Thanks to the UBT Resource Team in the Northwest, which provided source information used here. For more about run charts and how to create, use and understand them, visit ***LMPartnership.org*** *and type* run chart *in the search box.* (L+M)P

CLOSING THE GAP

It's not uncommon for teams to have a tough time meeting some of the Path to Performance requirements. Here's how Fresno took on training and sponsorship shortfalls.

In partnership: Among those who work in Fresno's 50 UBTS are Shirley Luckett, a senior clinical lab scientist and member of IFTPE Local 20 (this page); lab assistant Sophon Sar (opposite page, left); and OB/GYN medical assistants Eustolia Garcia, Laura Hayes (lead MA) and Christy Corona (opposite page, right, left to right). Sar, Garcia, Hayes and Corona are all members of SEIU UHW.

"What's holding you back?"

Fresno Medical Center leaders asked their 50 unit-based teams that question directly late last year, at the same time they asked the teams to assess themselves on the new Path to Performance standards.

The answers mirrored what facilities everywhere say are challenges: training and sponsorship. Of the seven attributes of high-performing teams laid out in the Path to Performance, those two are consistently the most problematic.

Across the organization, many teams had their Path to Performance ranking lowered as a result of the 2010 year-end assessment—including Fresno, which UBT Tracker identified as having the highest percentage of high-performing teams in the organization. Fresno saw its number of Level 5 teams drop by more than half, from 27 to 14.

But Fresno had a plan for 2011.

"Early on, when we got a look at the Path to Performance, we created a strategy," says Rick Senneway, Fresno's director of performance improvement. "The Path to Performance helped focus us. (It) became very clear what we needed to work on."

Even before they had the assessment results, Fresno leaders devised a 2011 UBT strategy for team development and performance improvement. It includes specific steps for moving teams at both ends of the spectrum along the Path to Performance.

"We're engaged with our union partners at all levels," says Jose DeAnda, medical group administrator. "At the UBT departmental level, (and) at the LMP Council level, by having each council member be a sponsor of UBTs and by having the sponsors report out at council meetings on how UBTs are performing."

The goals were twofold: Move at least six teams up from Level 3 to Level 4 or 5 by the end of 2011, and help five teams achieve measurable improvement. Year-end assessments were not yet finalized when *Hank* went to press, but there's optimism about the results.

"We did some good projects this year, and our affinity groups really helped," says Navneet Maan, Fresno's UBT consultant,

referring to a system where teams working on similar projects met and shared ideas.

With a mandate to increase the number of high-performing teams by 20 percent in 2012, other teams and facilities might glean some ideas from Fresno's three-pronged approach.

1. Improve the support network for teams

One of the first things Fresno did was to revamp its sponsor network, including:

- Assigning sponsors to work in labor and management pairs and matching them so they share similar work areas;
- Reducing the number of teams sponsors work with to no more than four;
- Establishing new agreements that give sponsors more flexibility for how they meet with teams (in person or via email); and
- Setting quarterly deadlines for reporting on team status at LMP Council meetings.

The new agreements clearly defined expectations for sponsors, says Lynn Campama, Fresno's assistant medical group administrator: "The role of the sponsor is about the performance of teams," not about team management. "Everybody is accountable."

Rather than trust that sponsors know how to be effective, Fresno used council meetings as a training opportunity. Sponsors received updated materials, ranging from a new form to help teams with meeting basics to information on the use of metrics and SMART (strategic, measurable, attainable, realistic/relevant, time-bound) goals. They also got forms to help collect team success stories and to help teams better manage UBT Tracker, the organization-wide system that helps teams report on and find effective practices.

In addition, "local resource network" members documented their particular expertise—be it UBT development, performance improvement, issue resolution and interest-based problem solving, attendance, service and workplace safety—and were assigned to teams needing that expertise.

"We took sponsorship to the next level," says Lorie Kocsis, Fresno's union partnership representative, LMP Council union co-lead and SEIU UHW member. "We tried to make their role easier for them to understand and to help them feel that they aren't alone."

Ron Barba, the director of the outpatient pharmacy and sponsor for the respiratory, inpatient and outpatient and surgery specialties teams, has noticed the difference.

"They gave us the training we needed to help the teams," Barba says. "I feel more effective."

2. Improve team training

To address training gaps identified by the teams, Fresno developed a brochure that puts all the offerings in one place—classroom, "just in time" and web-based training available through KP Learn—and groups the offerings by audience. That makes it easy to see what's available for team members and what's there for union and management co-leads.

At the same time, a request form for just-in-time training was developed, and both the brochure and the form were posted on Fresno's intranet website. A clear process for requesting training was put in place, with team members instructed to submit their requests to Kocsis and Maan.

It didn't stop there: Teams also got training in key partnership and performance improvement methods. A one-hour, just-in-time version of the eight-hour Consensus Decision Making (CDM) course was conducted with teams that requested or needed it. Teams working on non-payroll projects, such as reduction of inventory, were encouraged to take Northern California's new business literacy training.

"Training had been one of our big downfalls keeping teams from higher performance," says Debby Schneider, Fresno's LMP consultant.

The brochure has heightened awareness of what's available.

"It helps us see at a glance what we need to take," says Jeannine Allen, the administrative services supervisor and co-lead for the Adult Medicine UBT. "It's been kind of a road map."

3. Prioritize projects

To maximize the teams' performance improvement impact, Fresno guided them toward projects that were achievable, would impact facility or regional goals, and were aligned with the Value Compass.

Teams used a prioritization matrix (see "How to implement a facility-wide UBT strategy") to help them pick projects. That exercise sharpened teams' focus and enabled members to "see how the work they are doing impacts the entire service area—not just their departments," says Maan.

Teams shared ideas with their sponsors, who connected teams with other resources, including the experts in the newly established local resource networks and the affinity groups.

The experience of the Health Information Management team illustrates why such connections are invaluable. Its SMART goal was to improve customer service by way of a survey. Jeremy Hager, a care experience leader, was assigned to help the team.

He introduced the fishbone diagram to the team co-leads to help them identify which metrics the team should focus on to reduce customers' complaints. He also helped them correctly interpret survey data. (To read more about the team's work, see page 11.)

The affinity groups also helped teams. The six unit-based teams that made attendance a priority, for example, received tips, tools and specific training around the "six essentials of good attendance" identified by Ann Nicholson, LMP attendance leader for Northern California.

They also looked at their data going back several years, which "really made a difference," says Eileen Rodriquez, assistant manager for OB/GYN. "It was an 'aha' moment."

The team is meeting its attendance goals. With 6.17 sick days per full-time employee as of the first pay period in December, the team members exceeded the region-wide goal of 6.50. What made the difference? Managers are more flexible, and workers are more aware of the impact of missed days.

Staff members "feel comfortable coming to us," says Norma Costa, department manager—and the team's union co-lead, Lisa Madrigal, a medical assistant and SEIU UHW member, concurs.

"I know that if I need to take time off, I can go to my manager and talk with her about it and that she'll do everything she can to accommodate me," Madrigal says.

Coming in 2012

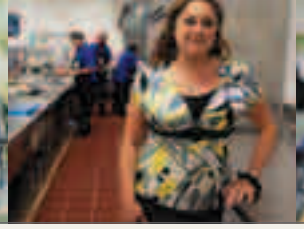
Attendance will continue to be a focus of the facility's UBT strategy for 2012—as will making it easier to use UBT Tracker. Refreshers on UBT basics will be provided, new tools introduced and new affinity groups created. And while local union steward elections will affect the sponsor pairings, sponsors will continue to get training and will continue to serve on the LMP Council in labor and management pairs.

*Visit **LMPartnership.org** for tools to help sponsors in their work, including a form to help guide discussions (type* six team talking points *into the search box).* (L+M)[P]

How to implement a facility-wide UBT strategy

1. **Provide sponsors and teams with ample and frequent training.** Offer frequent refreshers on Consensus Decision Making, Interest-Based Problem Solving, and the Rapid Improvement Model and its plan, do, study, act steps.
2. **Make good use of your local experts.** Work with your management and union leaders and your facility's project managers to identify their areas of knowledge and assign them to teams needing that expertise.
3. **Create one list that consolidates all the just-in-time, classroom and web-based (KP Learn) courses that meet Path to Performance requirements.** Make the list and course-request process easily accessible.
4. **Have sponsors and subject matter experts sit on the LMP Council and require regular updates.** Identify common issues and address them.
5. **Have teams do a "project prioritization matrix" annually after year-end assessments.** Download the tool at **LMPartnership.org/stories-videos/how-prioritize-team-goals**.
6. **Distribute and use LMP and performance improvement tools.**

AROUND THE REGIONS


'Our members love the service and quality they receive as patients at Kaiser Permanente.'

—**Meg Niemi**, president of Local 49

[COLORADO]

Errors drop with pre-op doubling up

Tensions were high and the Ambulatory Surgery Center UBT was fragmented when its members decided to tackle an ongoing problem—too many patients not receiving ordered antibiotics before going into surgery.

Surgeons often see patients and put in orders for antibiotics or anti-nausea medication, drugs that will help ensure a smooth recovery, up until a minute or two before surgery. Previously, by this point, the pre-operative nurse had handed off the patient and the order wasn't caught.

Now, before a patient is sent to the operating room, instead of one nurse reviewing a checklist, the pre-operative nurse and the OR nurse review the list together, including last-minute orders from physicians.

In less than two months of implementing the new system, the team went from 10.8 percent of missed antibiotic orders to 0.27 percent—or two out of 735 patients.

"With all the checks we do now, we almost never miss any orders," says Sara Dixon, RN, perianesthesia manager. The team has sustained its success for two years.

[NORTHWEST]

SEIU Local 49 adds 2,200 members to dental program

When SEIU Local 49 changed its benefit plan to make KPNW Dental Program its members' exclusive dental provider, it was a cause for celebration—representing the largest jump in dental program membership since 1998.

KP's sales and account management team, working with an outside broker and a task group of KP and Union Coalition leaders, developed a proposal that was more affordable than the plan offered under the SEIU Health and Welfare Fund trust.

"Our members love the service and quality they receive as patients at Kaiser Permanente," says Meg Niemi, president of Local 49. "It makes a lot of sense to them to be part of the Dental Program, since they are already receiving medical health insurance with KP."

Working in partnership to secure this account made sense to sales and account management staff.

"The strong ties and mutual goals are evident in the dental sale of Local 49," says Ehren Cline, senior account manager, Labor and Trust. "What is most important is that the Local 49 members will receive the best care at the best price."

[MID-ATLANTIC STATES]

One-page tool makes it easy for sponsors

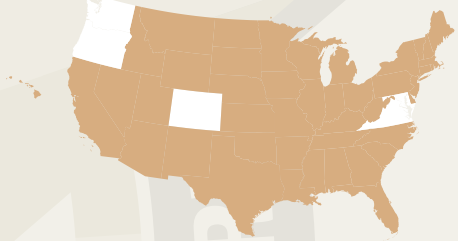
A simple tool developed by the Mid-Atlantic States region is helping teams and their sponsors stay current on the status of performance improvement work and identify barriers to advancement.

The reporting sheet allows team leads, in a concise format, to report to their sponsors a few key points, including:

- What tests of change the team is working on
- What they're learning
- Barriers they need help overcoming.

"This is a proactive tool that co-leads can use to communicate regularly with the sponsors," says Kevin Cornell, UBT metrics consultant for Mid-Atlantic States.

Visit ***LMPartnership.org*** *to download the tool (type* sponsor reporting tool *in the search box).* (L+M)P



FROM THE DESK OF HENRIETTA: Is your good job at risk?

I can't get that old Springsteen song "My Hometown" out of my head: "Foreman says these jobs are going, boys, and they ain't coming back…." That was a hit back in the early '80s, when auto, rubber and steel factories started closing in the Midwest.

Looking back from the ditch we're stuck in today, you can see that economic steamroller of devastation flattening industries and states.

Despite a few bubbles here and there, people keep losing their houses and their jobs, and let's face it—they ain't coming back anytime soon. Since 2000, the median income for ordinary Americans dropped by $2,197 per year. Most of us who are working feel fortunate to have any job at all. Those of us who have meaningful jobs—like keeping people healthy and caring for them when they are sick—we're really lucky.

At Kaiser Permanente, we've got more than good fortune on our side. Not only do we have good jobs, with industry-leading wages and benefits, but we've got a strategy to make them great: We take value creation to heart.

That's the point of the Value Compass—*creating value*.

As we work in our unit-based teams to improve service, quality and affordability and create the best place to work, we create more value for our members and patients, which will protect and improve our good jobs.

The Value Compass is not an initiative, a symbol or a checklist. It's a shared vision.

It reminds us the sum of team collaboration produces value greater than our individual efforts alone. It reminds us how important our contributions are—and why we work so hard at improvement. It acknowledges that work has meaning not just for the "leaders" but for everyone.

Of course, most people—except maybe the now-infamous 1%—create value at work. But we are doing it collaboratively and deliberately:

- We put the patient and member at the center of the Value Compass. That's not some corporate blah-blah like "put the customer first." It actually means something: The patient is at the center because that is who we are creating value for.
- Our value creation is balanced; the compass's four points are equally important. We're not working to create a best place to work while ignoring affordability, or to become very affordable while providing poor care.
- We believe every worker has a right not just to fulfill the duties laid out in an official "job description"—but to understand how the value he or she creates contributes to

PLAN, DO, STUDY, ACT

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

SHARE YOUR BEST PRACTICE

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

Data brings customer service to life

Department: Health Information Management, Fresno Medical Center

Value Compass: Service

Problems: Lagging turnaround time for patient information requests and lack of staff courtesy in person and on the phone

Metric: Complaints tracked by Member Services, a customer satisfaction survey generated by the team, and incomplete request reports.

SMART goal: To improve customer satisfaction from 84 percent in March 2011, per the staff-collected data, to 90 percent by the end of July 2011

Labor co-lead: Carla Duerksen, claims processor, SEIU UHW

Management co-lead: Isabel Lascano, director

Small tests of change:

- Reviewed customer satisfaction survey responses with entire team at weekly meetings and huddles. "Everyone took ownership because of the comments," which were both positive and negative, labor co-lead Duerksen says. "If they identified an employee by name and said (that person was) helpful…that reinforced that staff needed to be polite."
- Moved disability clerk and her phone to the front office, where she could better engage with customers and process their requests.
- Added a sign to direct members with disability questions and forms to one window.
- Provided restaurant-style pagers so patients needing to pick up records can wait comfortably elsewhere in the facility.

Results: Customer service complaints from Member Services about lack of courtesy dropped to zero, while satisfaction results per the staff survey remained high.

Biggest challenge: Distributing the customer service survey without skewing the results. First staff members self-selected whom they would give the survey to, and a volunteer who wasn't in the department collected the results. The team ultimately settled on distributing the survey to all members, who can then drop the surveys off in a locked box.

Side benefits: Disability claims information is released within two or three days of the request, compared with the previous 10- to 15-day lag time. Improved communication with physicians and others in departments holding records and other information needed to complete requests.

Background: The department receives up to 106 "release of information" (ROI) requests daily, a process that is governed by strict state and HIPAA privacy and time requirements.

Data team members looked at a year's worth of complaint reports from Member Services, which revealed issues with courtesy and efficiency, particularly for disability claim–related requests.

Looking at and collecting the data, Duerksen says, "made the staff aware of what the people think. It brought to life the importance of customer service and the perception of the customers."

Team members learned the majority of ROI were related to disability claims, which "contributed to us making changes in that area," says management co-lead Lascano.

For more information, contact the co-leads at Carla.Duerksen@kp.org or Isabel.Lascano@kp.org. (L+M)P

the whole, to the value our organization delivers to our members and the communities we serve.

Does a shared vision matter? According to the professors whose article "Building a Collaborative Enterprise" was published in the *Harvard Business Review* this summer, it's critical.

"A growing number of organizations—including Citibank, NASA, and Kaiser Permanente—are reaping the rewards of collaborative communities in the form of higher margins on knowledge-intensive work.… Kaiser Permanente's Value Compass… succinctly defines the organization's shared purpose. (It is) a recognition of the challenges that every member…has the responsibility to meet every day," wrote Paul Adler of the USC Marshall School of Business, Charles Heckscher of the Rutgers School of Management and Labor Relations, and Laurence Prusak, an independent consultant who teaches at Columbia University.

To be successful today, they continued, companies "need everyone's ideas on how to do things better and more cheaply.… The organizations that will become the household names of this century will be renowned for sustained, large-scale, efficient innovation. The key (is)…a strong, collaborative community."

Makes you feel pretty good about the ol' Value Compass, doesn't it?

Hold on, though. Things are about to get pretty uncomfortable. Health care reform means more patients, with more complex challenges, at lower reimbursement rates.

Over the next few years, we'll need our Value Compass more than ever. And maybe, just maybe, we can be so successful that this approach spreads to other workplaces.

Maybe we're onto a not-so-secret weapon for changing the world—something that can throw that steamroller of economic devastation into reverse. (L+M)P

CARTOON TO COME

TELL ME YOUR STORY

BRING PARTNERSHIP ALIVE

When you share the stories of your team's successes and challenges, you are showing everyone the way to better health care for all, inspiring others to follow your lead. Get tools to help you tell your team's story at **LMPartnership.org/storytelling**.

(L+M)P
The Power of Partnership

FOLD AND TEAR ALONG DOTTED LINE