

**LABOR AND EMPLOYMENT  
RELATIONS ASSOCIATION SERIES**

**THE EVOLVING  
HEALTH CARE LANDSCAPE**

**How Employees, Organizations,  
and Institutions Are  
Adapting and Innovating**

Edited By  
Ariel C. Avar  
Timothy J. Vogus

## Labor–Management Partnerships in Health Care: Responding to the Evolving Landscape

ADRIENNE E. EATON  
REBECCA KOLINS GIVAN  
*School of Management and Labor Relations  
Rutgers University*

PETER LAZES  
*Joseph S. Murphy Institute for Worker Education and Labor Studies  
City University of New York*

### INTRODUCTION

Over the past 20 years or so, unions and management have developed several significant joint projects in health care organizations to improve labor–management relations, increase efficiency, improve patient care and satisfaction, and create more meaningful work (Kochan, Eaton, McKersie, and Adler 2009). These partnerships have also helped the parties respond to changes in the health care landscape. In the U.S., labor–management partnerships have been an important and powerful process to improve the quality of services/products, control costs, and improve the quality of work life of employees as a result of front-line staff and union involvement (Eaton, Rubinstein, and Kochan 2008; Kochan et al. 2008; Rubinstein and Kochan 2001). Partnerships are both a business and a labor relations approach and are typically customized to address the issues of a particular organization, its workforce, and workforce representatives.

Partnerships feature increased union and worker involvement in managerial decision making and work reform. These processes have helped organizations remain competitive, create high-quality products and services, and provide meaningful work for employees (Lazes, Figueroa, and Katz, 2012; Maimonides Medical Center 2007). While overall there has likely been a decline in the number of labor–management partnerships in the United States, health care is one of the few sectors where they have continued to grow and develop (Eaton, Cutcher-Gershenfeld, and Rubinstein 2016).

Although there is also a record of partnerships and other forms of union–management collaboration in long-term care, in this chapter, we

focus on hospitals and health systems. We ask how labor–management collaboration in health care comes about, and when and how collaboration is successful.<sup>1</sup> We are guided in this by the general literature on labor–management partnership. Kochan and colleagues (2008), for instance, argue that partnerships are precarious and that to survive and flourish they need to put in place structures or practices that solve three specific strategic challenges: initiation, governance, and sustainability.

Eaton, Rubinstein, and McKersie (2004) identify, on the basis of data collected from more than 50 partnerships, specific factors that deal with a very similar list of challenges. Specifically, they argue that partnerships are usually formed in the context of a crisis, but they also require talented leadership and facilitation, “enabling language,” and “union capacity to engage in managerial decision making while maintaining [its representational role]” (Eaton, Rubinstein, and McKersie 2004: 9). Eaton, Rubinstein, and McKersie (2004) also identify factors associated with sustainability including, among others, achieving improvements in productivity or quality and ongoing management of the tension between collaborative and adversarial relations. This last factor has particular implications for how collective bargaining is conducted (Kochan, Eaton, McKersie, and Adler 2009: 87; Rubinstein 2001: 426). We attempt to explore these issues using six in-depth cases.

The health care industry has been rapidly changing in recent years. The high cost of care coupled with poor quality is pressuring health systems to change how they provide services. In addition, more patients, as a result of the Affordable Care Act (ACA), now have access to health insurance, which has resulted in increased demand at the same time that many hospital systems are merging and consolidating. More specifically, health systems are undergoing major changes that shift the focus from hospital-based care to integrated and more community-based care.

As the health care landscape continues to transform as a result of new quality requirements and changes in reimbursement, labor–management partnerships increasingly play a role in identifying and developing new systems of care. These changes require staff to work together in different ways. The jobs themselves are also significantly changing as a result of reimbursement shifting from a fee-for-service reimbursement process (getting paid for what is done during a particular hospital or physician visit) to an outcome-based process (Porter and Lee 2013).

### SIX KEY CASES

We selected six critical cases in order to understand the nature of collaboration between labor and management in health care.<sup>2</sup> Four of these cases are defined by the parties themselves as, and meet our definition of, “partnership,” while two involve more-limited forms of collaboration—

although they may evolve into partnerships. Space limitations did not allow for inclusion of additional cases, but we believe the cases we discuss are among—if not *the*—most extensive and interesting examples of labor–management collaboration currently ongoing in health care organizations in the United States.<sup>3</sup> We also wanted our cases to involve different unions to the extent possible.

The case studies were based on interviews, observation (sometimes participant observation), and documentary research. We examined meeting minutes, reports, collective bargaining agreements, and secondary literature. In most of the cases, at least one of us has had a consulting relationship to the partnership at some point. We interviewed key actors in each case, which generally included representatives of both union and management.

Labor–management projects in health care vary in origin—some emerge from crises in relationships, where conflicts arising from the bargaining and implementation of contracts were clearly detrimental to the functioning of the hospital organization. In other cases, parties saw an opportunity to make improvements to their organizations before crisis struck. The cases vary from broad partnership, in the case of Kaiser Permanente, to fairly narrow joint work, as in the case of the Committee on Interns and Residents’ quality improvement program. In each case, we try to draw out the origins of the partnership, the key areas for collaboration, the major stumbling blocks and successes, and the results of the collaboration.

We detail the collaborative processes, the resources that were allocated by labor and management, and some of the outcomes for the relevant stakeholders. We show that, while each case retains unique attributes, there are some common factors that demonstrate that collaborative relationships can be particularly productive in the health care workplace. We argue that health care is special, or exceptional, because it does not produce cars or steel rods, but rather it involves the care of human beings—with individual well-being and even lives at stake. Health care employees tend to identify with the mission of the organizations they work for, and it is likely easier for them to find common cause with management toward the goal of better patient care.

### University of Massachusetts Memorial Hospital and SHARE

SHARE, an AFSCME affiliate, represents 2,800 clerical, technical, and health care employees at the UMass Memorial Medical Center and another 500 at the UMass Medical School, both in Worcester, Massachusetts. UMass Memorial is a three-campus hospital system with almost 800 beds and more than 9,500 employees; it is also the clinical partner of the UMass Medical School (UMass Memorial Medical Center 2016).

SHARE was organized in 1997 and is part of a network of unions called the New England Organizing Project (NEOP), at the core of which is the

Harvard Union of Clerical and Technical Workers (HUCTW). HUCTW organized under the banner, “It’s not anti-Harvard to be pro-union” and has from its beginning taken a collaborative approach to labor relations. This has involved using interest-based, problem-solving tools to deal with grievances, as well as formal departmental level labor–management committees to work on various problems.<sup>4</sup> The NEOP model emphasizes one-on-one relationships between union staff and members and “participation by members in decisions at work, and partnership and collaboration with the employer” (New England Organizing Project, no date). As such, SHARE has taken the initiative to push for greater voice for members in patient care and quality improvement.

Recently, SHARE’s interest has been met with an open reception from the new CEO, Eric Dickson, and Dickson’s newly hired chief human resource officer, Bart Metzger, at UMass Memorial Healthcare. Dickson and Metzger are interested in improving what have been fractious relations with the system’s various unions and in involving workers in quality improvement efforts. Metzger has experience in the New York City health care system, where he was able to observe the important joint work done at Maimonides Medical Center (another case discussed in this chapter) and other hospitals, and more recently from Allegheny General Hospital, which has an ongoing joint labor–management partnership with the union SEIU Healthcare PA.<sup>5</sup>

More recently, SHARE has become heavily involved, working closely with the hospital’s internal process improvement office, the Center for Innovation and Transformational Change (CITC), in efforts to strengthen the hospital’s quality improvement efforts. The union has had a full-time union staff person assigned to this work since late 2014 and added a second person on a part-time basis in fall 2015. The full-time union staffer provides training for the workforce in “lean management” under the auspices of the CITC and coaches individual union members on their process improvement work. He also supports the two central, institution-wide elements of the process improvement work: Idea Boards and huddles.

Each department is supposed to have a bulletin board for identifying and posting work problems and new ideas for work processes and is supposed to huddle—that is, regularly meet in a fairly fluid and informal way—to discuss ideas posted on the board and move them through an implementation process. There is, in practice however, wide variation in how often departmental huddles are held and in who runs them—varying from management, doctors, SHARE members, or a rotation—and in the quantity and quality of ideas generated. Depending on the nature of the problem, it may be addressed internally by department staff or passed along to a department manager or supervisor or to CITC staff. Idea Boards and huddles are available (but not mandatory) for all hospital units, not just

those providing clinical care. For example, in Central Scheduling—not a direct care unit—there is a project focused on improving patient satisfaction by improving the quality of interactions with this call center.

It is interesting to note that, as of yet, there are no written agreements between labor and management about this process improvement work. Nor have the parties engaged in interest-based bargaining. There is, however, an innovation fund of \$1 million available to pay for improvements (generated from Idea Boards) that departments could not otherwise pay for.

There is also a history—again in some units—of Joint Working Groups that bring together managers, providers, union members, and union staff to discuss issues more generally. SHARE is talking with management about a more structured partnership with management, but at the time of this writing had decided to engage in this more bottom-up effort. The union believes strongly that members want to have a more direct role in process improvement activities as well as in improving quality of work-life issues. The main challenge thus far is the unevenness of implementation: some departments are quite invested and committed to the process, while others have not adopted any of the new practices, as evidenced by blank Idea Boards dotted around some units.

### **University of Vermont Medical Center<sup>6</sup> and AFT Nurses and Healthcare Professionals 5221**

The University of Vermont Medical Center (formerly Fletcher Allen Medical Center) serves as the main university teaching hospital in Vermont, comprising the Medical Center Hospital, University Health Center, and UVM College of Medicine. There are also 30 outpatient and community clinics serving approximately 51,000 patients annually. More than 1,650 registered nurses work in the University of Vermont Medical Center alongside 450 physicians and 147 advanced-practice registered nurses and physician assistants. The Vermont chapter of the AFT Nurses and Healthcare Professionals (VTNHP) division represents nurses and ancillary staff at the Medical Center Hospital only.

The joint labor–management partnership was forged in 2006 as a response to insufficient nursing staff ratios in the hospital, building on a previous 2003 agreement to set up a “safe staffing” joint committee. By 2006, it had become clear that management had not followed the recommendations of the joint committee. Initially, the union filed a grievance, which it was pursuing to arbitration. While preparing for the hearing, Jennifer Henry, then-president of the VTNHP local, traveled to Sunnyside Medical Center in Clackamas, Oregon (a Kaiser Permanente facility), to learn about partnership work there. She returned to Vermont committed to creating a similar process and became convinced that to achieve an effective “staffing composition,” the union and management needed to

develop a less adversarial and more problem-solving relationship with each other.

Henry convinced both the administration and her executive committee to drop the arbitration and design a joint process to implement strategies to improve staffing and restructure responsibilities in each unit of the hospital. This became known as the Model Unit Process (MUP), and it was eventually written into future agreements.

The MUP provides staff nurses, their managers, and nurse educators time to analyze patient and staff needs and determine the appropriate staffing of the unit to improve care delivery and work processes. Non-nurses, such as social workers, nursing assistants, ward clerks, physicians, and pharmacists, are included in these activities when appropriate. The MUP was written into the 2009–2011 collective bargaining agreement, “with the intent of creating a collaborative culture, reducing financial impact and building a systemwide approach to quality improvement.”<sup>7</sup>

In 2008, after careful review, labor and management leaders, along with their consultant, decided to take steps to improve their MUP program. Management and labor agreed that future MUP teams would work on two systemwide and two unit-based projects instead of working on as many projects as staff identified. This change helped future MUPs to focus so that they could develop concrete solutions by the time their education and analysis work was completed, usually taking six months. The unit-based projects were identified by a survey compiled by each unit before it started its MUP. Teams were encouraged to start with easy projects—ones considered “low-hanging fruit”—to be able to achieve results quickly so that staff nurses could see that the MUP would result in real decision making. Two of the common systemwide projects were infection prevention and improving communications.

A second goal was to expand opportunities for MUP teams to learn from each other as they went through their six-month cycle of education, analysis, and solution development. To facilitate that, MUP teams from several departments held their educational workshops together and shared their progress during the analysis phase of their work. At the end of the six-month process, they shared their results at an “Outcomes Congress” with the director of nursing and the president of the local union.

In addition to resolving significant staffing issues, staff nurses gained access to departmental budgets, enabling them to make informed decisions about resource use and understand what it takes to run a department from the perspective of a manager. Managers and nurse educators learned more details about the needs and issues of front-line staff. All units of the hospital have now been through a MUP, and the process has begun in outpatient and community health centers.

Along with hiring a consultant (jointly funded by the union and management) to conduct the seven educational/learning sessions, the hospital agreed to free up a union leader to work part-time to support MUP activities. As well as attending the educational sessions, this union leader is available to assist MUP teams by suggesting ways to gather data on specific problems and help team leaders address both systemwide and unit-based problems. This MUP advisor also works with Professional Practice Committees (PPCs)<sup>8</sup> to prepare them for their role in implementing agreements established by their MUP.

Once each MUP team finalizes its recommendations, as a result of feedback from other staff on their unit, they obtain approval for any changes and modified staffing levels from the president of the union and the director of nursing. It is the responsibility of the PPC for a particular unit to implement and sustain these activities.

The tangible results achieved included a reduction in patient falls (from three to two falls per 1,000 patient days) and a reduction in nurse position vacancies—resulting in \$8 million in cost savings and improved morale. Union membership has increased by 12% since the inception of the MUP, and the local’s members now include 300 tech workers. There are now about 2,100 members in the local union. As a result of improving PPCs and creating better communications among MUP teams, floor nurses are now more aware of the role of the union in creating a voice for them in the decision making in their unit.

Importantly, the labor–management effort at UVM has been able to weather turnover in labor and management leadership. There have now been three changes in the leadership of the local union and management since the inception of the MUP program in 2006. There remains a strong commitment to providing members with the opportunity to improve working conditions and patient care through the program.

There remain some significant challenges. One has been strengthening the work of the PPCs so that they are better able to implement and sustain MUP recommendations. As stated in the labor contract, physicians and other front-line staff members are not members of an MUP or a PPC, but they do attend specific education and training sessions on an as-needed basis. Their absence as active MUP team members reduces the ability of the teams to have access to their insights and knowledge and their involvement to make sure changes are implemented. There also continue to be difficulties documenting and communicating specific changes and outcomes. To some extent this is a result of the nurses not having time (other than during MUP training) to spend on documenting results. Finally, there doesn’t seem to be labor involvement in quality improvement and delivery system changes beyond the MUP program. Given the progressive nature

of Vermont health care, it would seem UVM might be an appropriate system in which to go beyond unit-based work to explore joint ways to provide more coordinated and integrated care for patients.

### **Los Angeles Department of Health Services and SEIU Local 721<sup>9</sup>**

The Los Angeles Department of Health Services (LA-DHS) is the second largest public safety-net health system in the United States. It includes four hospitals, two former hospitals that are now multiservice ambulatory care centers, 17 community health centers, and 161 community partner clinics (primarily Federally Qualified Health Centers) that provide primary care. It treats 750,000 patients annually, most of whom receive Medicaid or are uninsured, and employs 18,460 staff. The unions that represent workers at LA-DHS are SEIU Local 721, which represents most workers, including nurses; the Committee for Interns and Residents (CIR); and the Union for American Physicians and Dentists (UAPD), which represents attending physicians and dentists.

Since the appointment of LA-DHS director Mitch Katz and his team in 2011, labor and management have begun a comprehensive process of developing opportunities to work together. Both the SEIU international and SEIU Local 721 agreed that it was necessary to create a more integrated delivery system as a result of the ACA as well as to focus on improving access to care and the patient experience. An integrated delivery system focused on treating patients in a coordinated and proactive way could help meet the goal of keeping patients healthier and reducing unneeded hospitalizations.

In late 2011, the leadership of SEIU Local 721 began discussions with the new leadership of LA-DHS. The initial focus was on culture change, the re-enrollment of county residents so that they were eligible to receive LA-DHS services, and the expansion of unit-based teams known as care improvement teams (CITs). The interest in CITs was based on the awareness among union and management leaders of the success of similar activities at other health care institutions, such as Kaiser Permanente, and a recent labor-management partnership process with the Environmental Services Department at the Los Angeles County-USC Medical Center.

By 2013, both union and management leaders decided to deepen their joint process. A one-day retreat was conducted for senior union and management leaders to establish strategic areas of work as well as develop clear principles of engagement (a charter) for joint efforts. The four strategic areas were improving the patient experience, developing a systemwide quality and safety improvement process, expanding the development of CITs, and improving current labor-management committees. In addition, a Labor-Management Transformation Council (LMTC)<sup>10</sup> was created to

set strategic priorities, monitor key areas of work, and take corrective actions to ensure that needed changes were implemented. This group was also responsible for making sure that resources were available to support the development and implementation of changes and to develop appropriate tracking and monitoring systems for all joint work.

A social contract was created (i.e., principles of engagement) to make sure joint labor-management work was encouraged within all departments of LA-DHS. The composition of the LMTC includes senior management responsible for operations and medical staff in all four hospitals; Quality Improvement, CIT, and labor relations staff; and senior union leaders and the health care division staff of SEIU Local 721. When CIR and UAPD joined the labor-management partnership process, they were included on the council as well.<sup>11</sup>

At the LMTC retreat, specific groups were created to work on the strategic goals for the labor-management partnership process. Each labor-management work group had a labor and management co-chair and chose members from the LMTC or elsewhere within LA-DHS. In addition to the LMTC, the LA-DHS created the position of director of CITs to oversee the expansion of unit-based teams. Another four staff members (most of them rank-and-file employees) were released from their current jobs to serve as coaches/mentors to CITs. The union agreed to release one full-time staff person to work on the partnership with LA-DHS management.

In addition, the LMTC developed a comprehensive educational program known as CRMs (conference room meetings) to inform all front-line staff (from environmental service employees to attending physicians) why changes were needed to improve access, quality, and coordination of patient care. These educational activities were quite important because a large number of front-line staff were not aware of changes in reimbursement and the need to become a "provider of choice" as a result of the ACA (i.e., patients could now go elsewhere for care) and changes in state funding for uninsured and underinsured patients.

As the labor-management partnership process has deepened in terms of specific activities to improve the patient experience (such as reducing wait times) and patient care (access to a primary care provider), being an effective partner with management has been a challenge for the union and its staff. The union staff has had to develop new skills for this role. The union leadership also realized they needed to develop an extensive member communications strategy so that the union doesn't come across as "management sellouts," given that the union had not previously been involved in quality and system improvement activities.

So far, the LA-DHS/SEIU partnership has produced some significant positive outcomes. For instance, a systemwide set of emergency codes for all four hospitals and 17 ambulatory care settings has been implemented,

replacing multiple codes that were confusing and dangerous for both patients and staff. Patient satisfaction scores have improved for outpatient services in key locations as a result of greater access to care and reduced wait time to be seen by a primary care provider. A comprehensive training program has been developed for coders to ensure that LA-DHS receives appropriate reimbursement for services rendered.

Another positive outcome is that the local union has discovered a huge cadre of members who want to work with the union to give front-line staff a voice in decision making. Partnership activities “have mobilized significant numbers of members who see their union as providing them with opportunities to develop a voice and dignity at work while improving patient care,” said Gilda Valdez, chief of staff for SEIU Local 721.

Although the joint effort has resulted in major progress, the partnership still faces significant challenges. One is moving beyond unit-based activities to more outcome- or value-based work that is cross-functional or cross-unit (Porter 2010). A further challenge is moving from just treating a patient’s current condition to improving a patient’s overall health. Such an approach would build on the current quality improvement processes. An additional challenge for labor and management at LA-DHS is how to internally integrate current quality improvement and partnership activities, a common challenge in labor–management efforts (Eaton 1995; Litwin and Eaton, forthcoming). It will also be important to accelerate the coordination and integration of services between primary care, behavioral health, community organizations, and public health because many LA-DHS patients have complicated and co-morbidity conditions. Improving the coordination and integration of primary care and behavioral health services will help ensure that patients have greater access to mental health services as well.

#### **Maimonides Medical Center and CIR, NYSNA, and 1199SEIU<sup>12</sup>**

Almost 100 years old, Maimonides Medical Center is the pre-eminent treatment facility in Brooklyn, New York. Maimonides has approximately 600 beds, a staff of renowned physicians, and more than 70 primary care and subspecialty programs. In 2015, the hospital delivered over 8,500 babies and had more than 110,000 adult and pediatric ER visits. It is one of the largest independent teaching hospitals in the nation and trains more than 400 medical and surgical residents annually.

Maimonides started its labor–management partnership process (referred to as its Strategic Alliance process) in 1997—about the same time as Kaiser Permanente started its partnership. The joint vision of executive vice president Pam Brier (later CEO and president) and John Reid, vice president of 1199SEIU (later an executive vice president of the union), was to create

ways for labor and management to work together to meet the challenges of the rapidly changing health care environment. The innovative 1994 collective bargaining agreement between 1199SEIU and the League of Voluntary Hospitals and Nursing Homes (Maimonides is a member of the League) created language to encourage labor and management to work together to improve patient care in League hospitals and nursing homes. This innovative contract expanded the joint job security fund and the training and upgrading fund of the League to include additional money for education and consulting services for hospital and nursing homes, such as the 1199/League’s Labor–Management Project (Kochan, Eaton, McKersie, and Adler 2009; Maimonides Medical Center 2007).

From the beginning, 1199SEIU was an active partner<sup>13</sup> in the Strategic Alliance work at Maimonides. The New York State Nurses Association (NYSNA) was an original member of the Strategic Alliance but withdrew from 2002 to 2004 as a result of a jurisdictional conflict with 1199SEIU. The Committee of Interns and Residents (CIR) became recognized as a bargaining unit in 2004 and joined Strategic Alliance activities at that time.

The full involvement of physicians as well as all other front-line staff has been a key aspect of the partnership at Maimonides. Attending physicians sit on the Labor–Management Strategic Alliance Council (LMC), which oversees all of the partnership activities. All unions are members of departmental labor–management committees that have been established throughout the hospital.

From the inception of the Strategic Alliance, there have been three key structures. The LMC oversees and supports all joint work; it meets on a monthly basis to share information about changes in the hospital and community as well other issues that impact the hospital (i.e., funding issues, political action, joint lobbying, and innovation grants from the Centers for Medicare and Medicaid Services). This group establishes yearly goals for the Strategic Alliance process and priorities for joint work.

The council operates in a manner similar to that of the LMTC in Los Angeles. It assigns staff to support various work groups and departments. The council consists of senior management of the hospital (including the CFO), as well as several supervisors, leaders from the three unions, human resource/labor relations (HR/LR) staff, quality improvement and performance improvement staff, and front-line staff from specific departments where alliance work is taking place. In addition to this structure, the leaders from each of the three unions and senior management meet regularly (via the Joint Oversight Committee). At the department level are departmental labor–management committees (DLMCs) that oversee training, education and joint problem solving, and redesign activities. DLMCs are composed of union and management representatives and front-line staff. The Strategic Alliance process at Maimonides has been focused on

improving patient care and the patient experience and on creating meaningful jobs for staff. It is seen as a business strategy and therefore has the support of top management. It is driven by operations managers, not by labor relations.

Sizeable resources have been freed up to help establish and sustain the joint work. Three full-time front-line staff (called “developers”—one from each participating union) are assigned to support alliance activities, along with a manager in charge of organizational effectiveness. The developers, paid for by the hospital, are trained in process improvement and system innovation techniques by Cornell University advisors, quality improvement staff, and 1199/League Labor–Management Project staff. The developers are assigned to work with departments or work groups by the LMC. When work groups are established, front-line staff are released from their patient care responsibilities to work on problem-solving and work redesign activities (other staff on those units are scheduled to backfill the positions while staff work on Strategic Alliance activities). There is a hospital-wide budget for backfill for staff, the three developer positions, and for training of union and management about how to support the alliance process.

The Strategic Alliance process has developed over time, starting in its early phase with educational workshops for all employees about the importance of joint work to improve patient care and the quality of work life of employees, moving to establishment of DLMCs to work on a broad range of quality of care, workforce, and labor relations issues. The Strategic Alliance process deepened in the mid-2000s by creating several interdepartmental and systemwide areas of work. This process consisted of the following:

- Creating a joint hiring process for screening and hiring of managers and supervisors
- Establishing a “community of workers” process to improve respect and dignity among Environmental Service workers
- Establishing an environmental services study action team—an intensive employee-driven process to improve the cleanliness of the hospital
- Instituting a cardiology project to improve patient care that resulted in reducing call-bell response time and improving nurse-to-patient ratios
- Setting up a dispute resolution process for handling workforce and management issues appropriately and quickly

Driven by the commitment of the CEO, the Maimonides strategic alliance process has been proactively supported by HR/LR staff (something that is not always true in partnerships). These staff members have developed workshops for managers and supervisors to help them see the value in and master the skills necessary for front-line staff engagement in activities to improve the quality of patient care. In addition, HR staff have

helped to revise the employee orientation program in conjunction with the unions to highlight the importance of front-line engagement. HR staff have incorporated into the annual performance review of managers the extent to which their workers are involved in departmental changes. Finally, HR/LR staff have been members of the work group developing an alternative dispute resolution process to help resolve work-related problems, reducing the need for grievances and write-ups.

One strong indicator of the degree of the level of cooperation present in this partnership is the joint hiring process for all supervisors in which workers participate from the start of the process to the final recommendation. Top management assigned the HR department to support the joint process when they found it was being unevenly implemented, and the department produced a guide to the process.

In addition to internal funding by Maimonides Medical Center, the Labor–Management Project of the League of Voluntary Hospitals and Nursing Homes and 1199SEIU has funded some of the consulting and education services of the Cornell University Healthcare Transformation Project, as well as provided mentoring and coaching by their own staff.

Among the significant outcomes from the Strategic Alliance process at Maimonides are the following:

- A redesign of the preparation and delivery of special dietary meals by Food and Nutrition Department staff so that meals are delivered on time more than 90% of the time
- A reduction in wait time from Patient Transport for ER Radiology by 40%
- Increases in Hospital Consumer Assessment of Healthcare Providers and Systems scores (HCAHPS scores of patient experience) by 50% for cleanliness of patient rooms and public areas
- A reduction in response times to cardiac patient alarms of less than one minute
- Joint development of a contact/call center to provide appointment for patients and referral for physicians and to enable physician-to-physician communications
- A reduction in the number of patients returning to the intensive care unit after transferring to a step-down unit
- Improved psychiatric care for seniors
- A 36% reduction in labor-related grievances

Challenges ahead for the Strategic Alliance include forthcoming leadership changes (both the CEO of the hospital and the vice president of the union will be leaving the hospital) and a greater emphasis on ambulatory coordinated care.



### Committee of Interns and Residents

The Committee of Interns and Residents (CIR), has 14,000 members nationally, with concentrations in New York, California, and a handful of other states. In recent years, the union has placed considerable emphasis on quality improvement initiatives and patient safety. This focus has been for a number of reasons, including member physicians' emphasis on improving patient care, and strategically reaching members who may be less engaged by more traditional bread-and-butter union issues. The union first attempted to implement programs at the hospitals that seemed most amenable to joint quality improvement work, but those early efforts were sometimes a struggle, given the parties' lack of experience and the challenge of coordination. However, CIR did achieve some positive results and helped to build a better roadmap for future efforts.

With more experience and better language in collective bargaining agreements, including clear structures and processes, the next round of projects achieved better results. Those programs included creating house staff safety councils as a forum for residents to lead improvements in patient safety; instituting a blame-free culture for reporting errors and near misses; improving the process of medication reconciliation; and making follow-up calls to primary care physicians following patient discharge from the hospital. CIR's work has been aided by the new American Council for Graduate Medical Education requirement that quality improvement be part of medical training (Institute of Medicine 2010).

As CIR took on more—and more diverse—quality improvement projects, the union bargained for additional resources to build support structures for this work. This included funding for a Joint Quality Improvement Association (a separate nonprofit organization focused on quality improvement activities) and joint funds to pay for and incentivize quality improvement. CIR was able to negotiate funding for quality improvement projects as a result of surpluses in the health benefit fund for these employees; medical residents tend to be young and healthy, and thus are relatively inexpensive to insure. CIR was able to divert some of the savings from the benefit fund surpluses into quality improvement initiatives that would directly benefit patients. As one chief resident stated, “As residents we felt it was very important we tie in the benefits we were getting in our contract with the care we were providing to our patients; we wanted to connect those two in some way” (Jaltenor 2013).

The union is now working at numerous hospitals to implement quality improvement programs, although the status and progress of the programs are mixed. Current quality improvement activities by CIR (as of this writing) are initiated by residents and supported by a director who is a black belt in Lean Six Sigma (a certificate program to help develop process and quality improvement activities). She was hired in 2011 and promoted to direct the initiative in 2014.

The most successful quality improvement programs have active member-leaders and receptive hospital managers and medical directors. In some cases, committees have been formed, and communication between residents and attending physicians has improved. At times, however, it has been difficult to quantify outcomes. In some cases, the residents have developed a commitment to quality improvement and have begun to see it not only as a strategy to improve patient care but also a useful avenue for their own research and publications. The example of quality improvement at Maimonides Medical Center demonstrates a successful collaborative case where the union was instrumental in achieving a positive outcome with a direct impact on patient care.

There are about 450 residents working at Maimonides Medical Center (Maimonides Medical Center 2015). The residency program at Maimonides is one of the largest free-standing programs in the country (Cohen and Kantowitz 2012). In addition to the involvement in the Strategic Alliance activities with Maimonides Medical Center as previously described, CIR has engaged in specific quality improvement work at the medical center. The parties established a Joint Quality Improvement Committee in their 2011 collective bargaining agreement. The 2011 contract also included incentive bonuses for residents, to be paid out if the quality improvement initiatives were successful. In the most recent contract (2013–2016), the hospital contributed \$180,000 to the incentive pool to reward quality improvement work. The contract also provides funding for a quality fellowship, to be filled by a post-graduate resident.

One of the significant quality improvement activities at Maimonides was the medication reconciliation project. Medication reconciliation is a fundamental aspect of the safe provision of health care. It involves “collecting and maintaining a complete and correct list of patient medications” when the patient is discharged and at all transition points within the hospital (such as a transfer from the emergency room to an inpatient unit) to make sure the medications are safe and appropriate (Sedgh et al. 2013: 357; see also Institute for Healthcare Improvement, no date). This activity is essential in avoiding dangerous medication interactions and providing appropriate care; incomplete medication reconciliation is a massive problem in most health care settings, causing numerous avoidable errors (for more, see Duguid 2012).

The CIR intervention allowed resident leaders to educate their peers on reconciliation and why it matters; they implemented a smartphone-based tool that provided the reference material necessary for medical reconciliation. Some residents (members of the Joint Quality Improvement Committee) also became “super users.” That status allowed them to serve as a resource on the wards for other residents to observe and support the reconciliation process. These activities were extremely critical as Maimonides transitioned from a paper-based medication reconciliation process to one

that used electronic medical records. After one year, residents received an incentive bonus in several departments where compliance had improved by 20% or more (Sedgh et al. 2013). In some departments, medication reconciliation improved by more than 40% (Jaltenor 2013).

While it is clear that there are numerous routes to improved medication reconciliation, the successful path here depended on the partnership among the union, front-line staff, and management. The seed for the work emerged from bargaining, with the decision to create a joint committee and make incentive funds available (provided by the hospital) to achieve needed outcomes. The development and implementation of this comprehensive medication reconciliation process was overseen by a joint labor–management committee. CIR leaders, staff, and members were directly involved in the success of the project. As a medical director and executive vice president Dr. David Cohen stated, “The idea was that this had to be a project that materially improved patient care, materially changed the hospital operations in a positive way and that there would be a bonus attached if quantitative measures were achieved by the house staff” (Cohen and Kantrowitz 2012).

The outcomes of this labor–management partnership were clear improvements. Accurate medication reconciliation dramatically improved, and residents and management (who are also the faculty) were extremely positive about the experience of working together on this project. The improved accuracy of the medical reconciliation translates directly into improved patient care and patient safety. Residents were able to take ownership of their work and develop expertise that they passed on to new classes of residents. As one resident put it, “The residents own this process. We didn’t have the higher-ups in the hospital telling us what to do; we told them what we need to fix and how we were going to fix it and they gave us the institutional support to do it” (Cohen and Kantrowitz 2012).

Challenges to quality improvement initiatives for CIR have come when management was not interested in union involvement or when the members themselves did not show the interest or initiative to take on these projects.

### **Kaiser Permanente and the Coalition of Kaiser Permanente Unions<sup>14</sup>**

Kaiser Permanente is a complex organization. It brings together separate entities: the Kaiser Foundation Hospitals, the Kaiser Foundation Health Plans, and the Permanente Medical Groups operating in multiple regions of the country. Together, these organizations serve more than 10 million members (the vast majority in California) and employ almost 18,000 physicians and more than 200,000 other workers. The majority of these employees are represented by several national unions and 27 local unions and are covered, in addition to the national agreement negotiated by the

Coalition of Kaiser Permanente Unions, by around 40 local contracts. SEIU has the largest membership of all the unions. There are also unions representing workers at Kaiser that by choice do not participate in the partnership, the most significant of which, the California Nurses Association (CNA), represents thousands of nurses in Kaiser’s Northern California region.<sup>15</sup>

Kaiser is sometimes known as the HMO that labor built, an acknowledgment of the important role that union health plans played in the earliest days in bolstering and expanding the organization. It is a history that, at least arguably, helped pull the parties together. Despite this foundation, competitive pressures arising from the entry of new HMOs into Kaiser’s markets and Kaiser’s entry into new geographic areas put downward pressures on labor costs and led to labor strife beginning in the 1980s. The first step toward partnership took place in 1995 and involved the Kaiser unions forming a coalition to strategize how to confront Kaiser’s labor relations practices.

As Kochan, Eaton, McKersie, and Adler describe it, “Almost from the beginning ... the union coalition pursued two tracks: an adversarial approach focused on a corporate campaign and an approach to Kaiser around a partnership” (2009: 37). In large part, the push for partnership among some union leaders came from a desire to avoid, if possible, fundamental and lasting damage to what was a heavily unionized employer.<sup>16</sup> But partnership also gained enormous legitimacy through being supported by union leaders willing to use an adversarial approach if necessary (Eaton, Rubinstein, and Kochan 2008).

Kaiser leadership had also been thinking about a partnership approach for a long time, and eventually the leadership on both sides of the table came together in 1997 to hash out a partnership agreement that spelled out six initial goals:

- Improve quality health care for Kaiser Permanente members and the communities we serve.
- Assist Kaiser Permanente in achieving and maintaining market-leading competitive performance.
- Make Kaiser Permanente a better place to work.
- Expand Kaiser Permanente’s membership in current and new markets, including designation as a provider of choice for all labor organizations in the areas we serve.
- Provide Kaiser Permanente employees with the maximum possible employment and income security within Kaiser Permanente and/or the health care field.
- Involve employees and their unions in decisions.<sup>17</sup>

In 2002, the parties added a seventh goal: consult on public policy issues and jointly advocate when possible and appropriate.

Early on, the parties negotiated a union security/organizing agreement calling, among other things, for employer neutrality in regard to new union organizing, and an employment security agreement protecting individual employees. The parties also created a structure (called the Senior Partnership Council) to enable top leaders from management and unions to meet regularly to oversee all labor–management partnership work within Kaiser. A staff structure was developed at the national level, eventually to be known as the Office of Labor Management Partnership (OLMP). The OLMP was funded by the collectively bargained Labor Management Partnership trust, which by 2005 had an annual budget of \$16 million.

In its early stages, the partnership resulted in some intense, localized, and very successful projects. Two of those projects have received the most attention: one keeping open an optical lab that had been slated for closure and another involving the rapid opening of a new hospital through a joint process (Baldwin Hospital).

As is often the case, the partnership also changed how the parties approached collective bargaining. In the year 2000, for the first time, labor and management leaders engaged in a complex, interest-based process involving almost 400 representatives from the two sides. Perhaps even more importantly, and running counter to the dominant trend in labor relations, they also conducted centralized national bargaining. Since 2000, the parties have continued with both national and interest-based bargaining, adjusting the details of the process over the years (for details see Kochan, Eaton, McKersie, and Adler 2009, Chapter 6).

The partnership in its first decade generally did a good job repairing the labor relationship and at focused projects aimed at improving quality or cutting costs while preserving employment security. Employees indicated in both employer and union surveys that they were more satisfied with their work, and many organizational metrics had improved (see Kochan, Eaton, McKersie, and Adler 2009, Chapter 11, for a thorough discussion of outcomes). At the same time, given Kaiser Permanente's size and complexity, the partnership took different forms and levels of intensity, from facility to facility. Overall, it struggled to involve wide swathes of members in workplace decisions or in transforming care delivery.

In 2005, the parties negotiated ambitious language to create unit-based teams (UBTs) throughout the organization; the language included specific targeted percentages of the workforce for each year. In the course of implementing the UBT language and the 2005 agreement generally, the parties concluded that UBTs would also be the vehicle to work on other organizational improvements, one of which was service quality, throughout the organization. Each region set goals for UBTs, including region-specific issues such as reduced absenteeism (southern California) and

improved collection of patient/member co-payments (also known as revenue capture, which was a northern California issue).

The parties claimed to have reached the goal of 100% coverage of the partnership workforce with UBTs by 2010. In the new agreement reached in that year, the goals focused on steadily increasing the portion of teams that were “high performing” as measured on an internal five-point scale. According to Kochan (2016: 256), “By January 2012, 3,458 teams were operating [within the organization]. ... [B]y December 2012, 40 percent of teams had reached the ‘high performance’ level.” The latest collective agreement, reached in 2015, calls on UBTs, for the first time, to include member and patient voices.<sup>18</sup>

Despite a serious effort by the parties to track both the functioning and outcomes of UBTs, because teams work on a huge array of specific projects with very different goals, systematic research on outcomes has been difficult. Internal Kaiser research has found, however, that higher-performing UBTs are associated with significantly higher HCAHPS (patient experience survey) scores on four specific measures, the overall hospital rating, and with much lower injury rates (Kochan, 2016, Figures 11.1 and 11.3: 257–258).

Overall, the partnership at Kaiser has been reasonably successful at accomplishing the parties' mutual goals. If nothing else—and there is in fact a lot else—simply surviving almost 20 years through leadership changes on both sides of the table, intense environmental pressures, and equally intense inter- and even intra-union conflict is remarkable. Interestingly, President Obama recently credited the LMP with helping to make Kaiser one of the leading providers of health care in the United States.<sup>19</sup> The deep institutionalization of the partnership would appear to increase the likelihood that the parties will be able to take on the challenge of providing lower-cost health care needed to compete in the new ACA-created individual markets and to weather the shift of health care to more community settings.

### COMMON THEMES FROM CASE STUDIES

As hospitals, health systems, and unions representing health care workers adjust to extensive changes in the health care landscape, the record so far on labor–management partnerships indicates that they can play a major role in achieving sustainable outcomes of improved patient care and control of inappropriate costs while creating meaningful work for employees through front-line staff involvement. On the basis of the case studies presented and lessons from other significant labor–management partnership processes in health care, we now summarize common themes. We begin with points that are common to these cases but that are not particularly new to those familiar with labor–management partnerships. We then turn to themes that are new and particular to health care.

### Applying the Labor–Management Partnership Literature to Health Care

One of the challenges identified in the partnership literature is the handling of modes of interaction across the different areas of the labor–management relationship, including collaborative work, collective bargaining, and grievance handling. The parties often find it contradictory to engage in joint problem-solving approaches to improve patient care while conducting daily labor relations and bargaining in more traditional ways (Kochan, Eaton, McKersie, and Adler 2009: 87; Rubinstein 2001: 426). Most of the organizations discussed in this chapter make use of a combination of interest-based bargaining and alternative dispute resolution to achieve some degree of alignment in the relationship. That is, they engage in a problem-solving approach for all interactions.

The literature also references the importance of enabling contract language (Eaton, Rubinstein, and McKersie 2004). Specific contract language has been quite helpful in sustaining and spreading partnership activities, particularly when there is a leadership change for either party. For at least two decades, the labor movement has pushed for partnership language to be included in contracts (AFL-CIO 1994; Lazes, Figueroa, and Katz 2012) to clarify the methods and principles of engagement as well as to create needed structures and resources that will help sustain this new way of working together and can't be eliminated at the whim of new management.<sup>20</sup> Most of the cases presented in this chapter have developed specific contract language that denotes the focus, structure, goals, and resources.

As was the case in prior labor–management partnerships, governance structures and principles of engagement (which include agreements to free up staff to support and assist the partnership), budgets to allow front-line staff time to work on designated problems, and employment security clauses have been critical for the success and sustainability of joint problem solving and system redesign (Kochan, Eaton, McKersie, and Adler 2009; Lazes, Figueroa, and Katz 2012). Eaton, Rubinstein, and McKersie (2004) point to the need for both strong, proactive labor and management leaders and the restructuring of union locals to build capacity and to convince staff and employees to work together in new ways (see also Lazes and Savage 2000; Rubinstein 2001).

In many of the cases cited in this chapter, additional resources and release time were bargained, sometimes supplemented with resources from joint labor–management funds. Proactive union and management leadership continues to be a critical factor in creating and sustaining a significant labor–management partnership process. Eaton, Rubinstein, and McKersie (2004) also point to the achievement of important outcomes such as productivity or quality gains as a foundation for sustainability of

partnership, and we clearly see those kinds of gains in the cases we examined, although sometimes limited to particular organizational niches.

We know from the literature on partnership that, historically, some learning took place among and across partnerships. Many labor–management partners interested in developing a partnership, for instance, visited GM's Saturn plant during its heyday (Rubinstein and Kochan 2001: 112–15). Indeed, leaders of one of the earliest joint projects under the Kaiser partnership visited Saturn as well as other joint models during the development phase of their partnership process (Kochan, Eaton, McKersie, and Adler 2009: 56). Union and management representatives at Kaiser also visited and learned from the multi-employer health care partnership in the Twin Cities of Minnesota (see endnote 3).

We think it is important to note that the cases described here have influenced one another because the key stakeholders have directly learned from each other. Representatives from SHARE are learning from the UVM case and from Allegheny Health Network. Union and management stakeholders in the Los Angeles case as well as union leaders from UVM have also looked to Kaiser for lessons. Union representatives from many locals cited in this chapter attended workshops at Cornell University in 2008, 2009, and 2010 specifically to share their different experiences. Consultants for all of our case studies have helped connect clients with others doing similar work and shared lessons learned from previous partnerships. In short, there has been much cross-learning taking place that influences the approaches of the organizations discussed in this chapter.

### Lessons for the Health Care Sector

There are also several aspects of these cases that we see as new and challenging, either because of the point at which they've developed in the trajectory of labor–management partnerships in the United States (i.e., they have learned from earlier cases and been able, therefore, to take things to another level) or because of the unique aspects of health care as a sector.

What is particularly striking across these cases is the extent to which unions have been proactive in driving these efforts. Each of the partnerships were developed either mutually (Kaiser Permanente, Maimonides) or as a result of long-term, determined pushes from the union(s) involved (AFT at UVM, CIR at Maimonides, and SHARE at UMass). In some cases, these efforts are a result of strategic approaches by the unions—either at the national or local level—to get out in front of the constantly changing health care landscape. AFT, CIR, and SEIU internationals have taken the initiative to learn about best practices for improving health care outcomes (e.g., a sector strategy moving to an integrated care delivery system, improving the quality of each aspect of patient care, creating patient-centered medical homes, integrating psychiatric and primary care services,

workforce development) and have encouraged their locals to incorporate these new areas of work within the goals and practices of their local. This being said, it has been a challenge for union locals to free up and prepare their staff to partner with management to develop new services and new jobs.

Another aspect of health care labor–management partnerships that is different from most previous partnerships is the presence of multiple unions<sup>21</sup> and the need to include all front-line staff involved in departmental and system changes. These health care organizations, to a large extent, have multiple bargaining units. At the most extreme end, we see the Kaiser partnership with ten different national unions participating, but other unions representing significant numbers of workers that are, for ideological reasons, choosing not to be part of the partnership.

Fundamentally, given the nature of health care delivery as a cross-functional, interdisciplinary enterprise, team work and collaboration are critical: it is a major barrier when important stakeholders are not at the table (whether in a union or not) in efforts to alter work practices and policies. At Kaiser, this issue has arisen with nurses in the northern California region and, at times, with physicians throughout the organization. At UVM and Allegheny General Hospital, only the nurses are involved in labor–management partnership activities. To some extent, this situation has been an issue of design. At UVM, management and the AFT local have structured their partnership process to focus on AFT members, whereas at LA-DHS and Maimonides all stakeholders are included in partnership work—even employees who are not members of a union. Layered on top of the problem of multiple occupations and multiple unions is the strong nature of hierarchy in health care. While it's important for all occupational groups to participate, it is also challenging for less-educated or -skilled workers to use their voices and to have them heard.

Also essential to understanding partnerships in health care is the 24/7 nature of operations and the tight staffing in most acute care facilities. Partnership activities necessitate front-line worker involvement in gathering data, problem solving, and testing solutions. This means time away from direct patient care. At Kaiser this issue was defined largely as one of “backfill”—how to fund workers to free up other workers for partnership training and work sessions (Kochan, Eaton, McKersie, and Adler 2009: 83). With the arrival of UBTs at Kaiser, the organization solved the problem, at least in part, with quick huddles (see Eaton, Konitsney, Litwin, and Vanderhorst 2011 for a discussion of huddles and other innovative solutions to the problem of meetings for UBTs).

UMass Memorial is also using huddles and has assigned executives to huddles; SHARE also has a union staff member assigned to work solely on process improvement activities. CIR and Maimonides, LA-DHS, and UVM have established agreements so that front-line staff have the time

to meet in work groups and serve on governance committees. This has sometimes meant having other staff come in early or stay over their shift. Even with these agreements, it can remain difficult to free up staff to join a partnership activity if there is a need for direct patient care.

Several partnerships have also decided to address both bottom-up problems (e.g., departmental and unit quality problems identified by front-line staff) as well as to focus on strategic needs (e.g., integrating primary care and behavioral health; establishing patient-centered medical homes) to transform their systems to be more integrated and patient centered. This joint focus on delivery system transformation goes well beyond what was typically seen in prior non–health care partnerships. These efforts also demonstrate the differences between hospital workers and those working in manufacturing settings. Rather than just being employed, health care workers have chosen to work in occupations that have a direct impact on others. They therefore seem to be more open to opportunities that give them voice in improving patient outcomes. We speculate that in manufacturing, workers may be less likely to offer suggestions that might simply increase profits for the owners of the business.<sup>22</sup> It is interesting to note in this regard that two of our cases—Kaiser Permanente and UMass Memorial—seek to involve patients directly in the problem identification and solving process. This suggests both the centrality of the patient in health care and possibly a new direction in labor–management collaboration whereby an additional stakeholder is not just discussed but actually is present in quality improvement processes.

Another development in health care partnerships has been a significant deepening of the role of labor relations staff in operational matters and extensive involvement of operations staff. Under a partnership, LR staff focus more on understanding and supporting operational changes (the creation of patient-centered medical homes, the implementation of electronic health records, etc.). They typically have primary responsibility to develop and deepen the use of interest-based tools and alternative dispute resolution that we discussed in this chapter. HR and LR staff have also been important in helping labor and management leaders anticipate and develop training of employees for new roles and responsibilities as the health care industry changes (community health workers, mental health advisors, etc.). Although some of those areas cited in this chapter were the responsibility of LR staff in prior partnerships—there is a deeper involvement in all of these areas.

Health care partnerships have also required intensive work to increase the knowledge and skills of the union staff about changes in the industry and methods that are needed to achieve them. This has been a priority for AFT, CIR, and SEIU at the national as well as local levels. These unions have decided that helping their members have a voice in

improving care will result in more meaningful work and greater connection/engagement of members to the union. The unions in these cases see partnership as a mode of union building as well as a path to improving both patient care and relationships with management.

## CONCLUSION

Although labor–management partnerships have existed in other sectors of the economy, the pace of change in health care organizations creates an environment where collaborative work may have a high chance of success. Unlike manufacturing organizations where many jobs have the potential of being outsourced and moved outside of the United States (giving employers a strong exit option), health care is still largely delivered in person. Health care’s rootedness creates incentives for unionized employers to engage collaboratively with their unions. Collaborative projects and broader labor–management partnerships can ensure there are processes in place to allow continuous improvement, develop new systems to improve access and coordination of care, and maintain the financial health of the facility to avoid cuts and layoffs. The organizations we’ve described in this chapter have also had the advantage of learning from roughly three decades of labor–management partnership practice in other sectors.

The literature on labor–management partnership has identified many challenges and barriers to successful partnerships and union–management collaboration more broadly. Our review of six key cases suggests that those same challenges exist in health care along with several unique to the industry. At the same time, these challenge can be met and barriers overcome. For practitioners on either side of the table thinking about pursuing a collaborative path, it is important to recognize the problems that will be encountered along the way.

Proactive labor and management leaders have been a critical prerequisite for a robust partnership process. In an environment where change is rapid and continuous, union and management health care leaders will need the dexterity and readiness to adapt their approach to partnership and collaboration in order to respond to ever-changing patient and organizational needs.

## ENDNOTES

<sup>1</sup> We use the terms “partnership” and “collaboration” somewhat interchangeably here. In our view, partnerships are more extensive and involve deep and wide forms of both union and worker participation in decisions formerly reserved for management. By “deep,” we mean the extent to which they provide opportunities for decision making for front-line staff. By “wide,” we mean the scope of decisions being made or range of topics discussed. While all partnerships feature union–management collaboration, some forms of collaboration are more focused or narrow and do not rise to the level of partnership.

<sup>2</sup> Critical cases are those that are most likely to “yield the most information and have the greatest impact on the development of knowledge” (see Patton 2002: 236).

<sup>3</sup> There are other important health care cases worth noting here. One is the on-again, off-again (but currently off) multi-employer, multi-union partnership in the Twin Cities (Minnesota), along with the spin-off partnership based in the Allina system (see Preuss 1998 and Preuss and Frost 2003). The second is the 1199SEIU–League of Voluntary Hospital and Nursing Home process. The third is the relatively recent labor–management partnership, again involving SEIU, at Allegheny Health Network in western Pennsylvania. The authors of this chapter have reviewed material on and are familiar with these three cases and have taken them into account in the analysis at the end of the chapter. In addition to these cases, there was a significant level of labor–management partnership in the Veterans Health Administration during the Clinton administration (Masters, Albright, and Eplion 2006).

<sup>4</sup> For a discussion of their problem-solving approach, see <http://bit.ly/29JZOSK>.

<sup>5</sup> Allegheny General Hospital has developed an important labor–management partnership with their SEIU local that is focused primarily on quality improvement and nursing issues.

<sup>6</sup> Peter Lazes, one of the authors of this chapter, provided limited consulting assistance to the leadership of AFT Local 5221 several years ago.

<sup>7</sup> Article 20B, 2009–2011 collective bargaining agreement.

<sup>8</sup> A professional practice committee is a work group composed of staff nurses, their nurse educator, and nurse manager on each unit of the hospital. This group is responsible for identifying and working on important nurse practice issues. The agreement to have PPCs is written into the union contract.

<sup>9</sup> Peter Lazes, one of the authors of this chapter, has been a consultant to the leadership of LA-DHS and SEIU Local 721 for several years.

<sup>10</sup> At the time that the LMTC was developed, there were about 20 unit-based CITs at one of the ambulatory care facilities. These teams were not connected at that time to an overall partnership process.

<sup>11</sup> Eventually, operations staff from the Los Angeles Department of Mental Health and the Los Angeles Department of Public Health joined the LMTC.

<sup>12</sup> Peter Lazes, one of the authors of this chapter, was a consultant to Maimonides Medical Center, CIR, NYSNA, and 1199SEIU from 1997 to 2013.

<sup>13</sup> There was a brief period when 1199SEIU withdrew from the Strategic Alliance during negotiations in 2009.

<sup>14</sup> Adrienne Eaton, one of the authors of this chapter, served as a consultant to the Coalition of Kaiser Permanente Unions for many years and received grants from both the coalition and Kaiser Permanente to conduct research on the partnership.

<sup>15</sup> For a discussion of CNA’s objections in the early stages of the labor–management partnership with Kaiser Permanente, see Kochan, Eaton, McKersie, and Adler 2009: 43–45.

<sup>16</sup> This was also a moment in time when there was a lot of discussion about partnership floating around the labor movement following publication of *The New American Workplace* in 1994 by the AFL-CIO. Further, Peter diCicco, at the time the head of the AFL-CIO’s Industrial Union Department but eventually the first executive director of the Coalition of Kaiser Permanente Unions, drew on his personal experience with job enrichment as an officer of the International Union of Electrical Workers at a General Electric plant in Massachusetts.

<sup>17</sup> See Kochan, Eaton, McKersie, and Adler 2009: 46 for excerpts or <http://bit.ly/29K15cy> for the full original partnership agreement.

<sup>18</sup> See <http://bit.ly/29EiHDd>.

<sup>19</sup> See <http://bit.ly/29K1xYj>.

<sup>20</sup> But see also "Partnerships of Steel" (Rubinstein 2003) for a discussion of the costs as well as benefits of a top-down contractual approach.

<sup>21</sup> The AT&T Workplace of the Future partnership did include two different unions. Eaton (1995) reports that the relations between the two unions were often as fraught as the relationship between the unions and management. For a full discussion of inter-union relationships at Kaiser, see Kochan, Eaton, McKersie, and Adler 2009, Chapter 7; and Eaton, Rubinstein, and Kochan 2008.

<sup>22</sup> While this is truly speculative on our part, we do know that Kaiser Permanente conducted internal research in 2004 (the Looking Glass project) that showed very strong identification with the mission of the organization and desire to provide or contribute to providing high-quality care throughout its workforce.

## REFERENCES

- AFL-CIO. 1994. "The New American Workplace: A Labor Perspective." Washington, DC: Committee on the Evolution of Work.
- Cohen, D., and M. Kantrowitz. 2012. "Resident Physician Engagement in Medication Safety Through a Labor-Management Partnership." Video. <http://bit.ly/29KthMv>.
- Duguid, Margaret. 2012. "The Importance of Medication Reconciliation for Patients and Practitioners." *Australian Prescriber* 35, no. 1: 15-19.
- Eaton, A. E. 1995. "Educating for AT&T, CWA and IBEW's Workplace of the Future." In *Proceedings of the Forty-Seventh Annual Meeting of the Industrial Relations Research Association*, Washington, DC, January, pp. 383-90.
- Eaton, A. E., J. Cutcher-Gershenfeld, and S. A. Rubinstein. 2016. "Labor-Management Partnership in the United States: Islands of Success in a Hostile Context." In *Developing Positive Employment Relations: International Experiences of Labour Management Partnership*, edited by A. Wilkinson and S. Johnstone. New York, NY: Palgrave Macmillan.
- Eaton, A. E., D. Konitsney, A. S. Litwin, and N. Vanderhorst. 2011. "The Path to Performance: A Study of High-Performing Unit-Based Teams at Kaiser Permanente." Kaiser Permanent Labor Management Partnership, February. <http://www.lmpartnership.org/rutgers>.
- Eaton, A. E., S. A. Rubinstein, and T. A. Kochan. 2008. "Balancing Acts: Dynamics of a Union Coalition in a Labor Management Partnership." *Industrial Relations: A Journal of Economy and Society* 47, no. 1: 10-35. doi:10.1111/j.1468-232x.2008.00502.x.
- Eaton, S. C., S. A. Rubinstein, and R. B. McKersie. 2004. "Building and Sustaining Labor Management Partnerships: Recent Experiences in the U.S." *Advances in Industrial and Labor Relations* 13: 137-56. doi: 10.1016/s0742-6186(04)13005-9.
- Institute for Healthcare Improvement. No date. "Reconcile Medications at All Transition Points." <http://bit.ly/2aolnsT>.
- Institute of Medicine. 2010. "ACGME Board of Directors Approved New Requirement for Residency Programs." Washington, DC: National Academies of Sciences. <http://bit.ly/29GD2aX>.

- Jaltenor. 2013. "Maimonides Residents Gain Notice for Medication Reconciliation." *CIR Vitals*, February 25. <http://bit.ly/29GD3LL>.
- Kochan, T. A. 2016. "The Kaiser Permanente Labour Management Partnership: 1997-2013." In *Developing Positive Employment Relations: International Experiences of Labour Management Partnership*, edited by A. Wilkinson and S. Johnstone. New York, NY: Palgrave Macmillan.
- Kochan, T. A., P. S. Adler, R. B. McKersie, A. E. Eaton, P. Segal, and P. Gerhart. 2008. "The Potential and Precariousness of Partnership: The Case of the Kaiser Permanente Labor Management Partnership." *Industrial Relations: A Journal of Economy and Society* 47, no. 1: 36-65. doi:10.1111/j.1468-232x.2008.00503.x.
- Kochan, T. A., A. Eaton, R. McKersie, and P. Adler. 2009. *Healing Together: The Labor Management Partnership at Kaiser Permanente*. Ithaca, NY: ILR Press/Cornell University Press.
- Lazes, P., M. Figueroa, and L. Katz. 2012. "How Labor-Management Partnerships Improve Patient Care, Cost Control, and Labor Relations." Washington, DC: American Rights at Work.
- Lazes, P., and J. Savage. 2000. "Embracing the Future: Union Strategies for the 21st Century." *Journal for Quality and Participation* 23, no. 4: 18-23.
- Litwin, A. S., and A. E. Eaton. Forthcoming. "Complementary or Conflictual? Formal Participation, Informal Participation, and Organizational Performance." *Human Resource Management*.
- Maimonides Medical Center. 2007. "Creating Competitive Advantage in a Changing Health Care Environment through Worker Participation: Strategic Alliance Report 2007." Brooklyn, NY: Maimonides Medical Center.
- Maimonides Medical Center. 2015. "Medical Education: Fellowship, Residency and More." Brooklyn, NY: Maimonides Medical Center. <http://bit.ly/29GNvmv>.
- Masters, M. F., R. R. Albright, and D. Eplion. 2006. "What Did Partnerships Do? Evidence from the Federal Sector." *Industrial and Labor Relations Review* 59, no. 3: 367-85.
- New England Organizing Project, no date. "About New England Organizing Project." <http://bit.ly/2aLjinA>.
- Patton, M. Q. 2002. *Qualitative Research and Evaluation Methods* (3rd edition). Thousand Oaks, CA: Sage.
- Porter, M. 2010 (Dec. 23). "What Is Value in Health Care?" *New England Journal of Medicine*, pp. 2447-81.
- Porter, M., and T. E. Lee. 2013 (Oct.). "The Strategy That Will Fix Health Care." *Harvard Business Review*, pp. 1-19.
- Preuss, G. A. 1998. "Committed to Care: Labor-Management Cooperation and Hospital Restructuring." Washington, DC: Economic Policy Institute. <http://bit.ly/29GOUdW>.
- Preuss, G. A., and A. Frost. 2003. "The Rise and Decline of Labor-Management Cooperation: Lessons from Health Care in the Twin Cities." *California Management Review* 45, no. 2: 85-106.
- Rubinstein, S. A. 2001. "The Local Union Revisited: New Voices from the Front Lines." *Industrial Relations: A Journal of Economy and Society* 40, no. 3: 405-35.
- Rubinstein, S. A. 2003. "Partnerships of Steel—Forging High Involvement Work Systems in the US Steel Industry: A View from the Local Unions." *Advances in Industrial and Labor Relations* 12: 117-46.

- Rubinstein, S. A., and T. A. Kochan. 2001. *Learning from Saturn*. Ithaca, NY: ILR Press/Cornell University Press.
- Sedgh, S., M. Kantrowitz, S. Shamah, A. Agarwal, V. Fernandez, and D. Cohen. 2013. "Q-Tip: Resident-Driven Quality Improvement to Inpatient Medication Reconciliation in an Academic Setting." *American Journal of Medical Quality* 28, no. 4: 357. <http://bit.ly/29GQZ8P>.
- UMass Memorial Medical Center. 2016. "About Us: Statistics." <http://bit.ly/29GR1FE>.

IN  
In  
cer  
an  
"I v  
/   
mec  
Wit  
scrib  
B  
have  
Perm  
safely  
she s  
secret  
Al  
larges  
and pl  
go awa  
ment,  
and th  
it, and  
Perma  
mation  
The  
Labor I  
compre



<sup>17</sup> See Kochan, Eaton, McKersie, and Adler 2009: 46 for excerpts or <http://bit.ly/29K15cy> for the full original partnership agreement.

<sup>18</sup> See <http://bit.ly/29EiHDd>.

<sup>19</sup> See <http://bit.ly/29K1xYj>.

<sup>20</sup> But see also "Partnerships of Steel" (Rubinstein 2003) for a discussion of the costs as well as benefits of a top-down contractual approach.

<sup>21</sup> The AT&T Workplace of the Future partnership did include two different unions. Eaton (1995) reports that the relations between the two unions were often as fraught as the relationship between the unions and management. For a full discussion of inter-union relationships at Kaiser, see Kochan, Eaton, McKersie, and Adler 2009, Chapter 7; and Eaton, Rubinstein, and Kochan 2008.

<sup>22</sup> While this is truly speculative on our part, we do know that Kaiser Permanente conducted internal research in 2004 (the Looking Glass project) that showed very strong identification with the mission of the organization and desire to provide or contribute to providing high-quality care throughout its workforce.

## REFERENCES

- AFL-CIO. 1994. "The New American Workplace: A Labor Perspective." Washington, DC: Committee on the Evolution of Work.
- Cohen, D., and M. Kantrowitz. 2012. "Resident Physician Engagement in Medication Safety Through a Labor-Management Partnership." Video. <http://bit.ly/29KthMv>.
- Duguid, Margaret. 2012. "The Importance of Medication Reconciliation for Patients and Practitioners." *Australian Prescriber* 35, no. 1: 15-19.
- Eaton, A. E. 1995. "Educating for AT&T, CWA and IBEW's Workplace of the Future." In *Proceedings of the Forty-Seventh Annual Meeting of the Industrial Relations Research Association*, Washington, DC, January, pp. 383-90.
- Eaton, A. E., J. Cutcher-Gershenfeld, and S. A. Rubinstein. 2016. "Labor-Management Partnership in the United States: Islands of Success in a Hostile Context." In *Developing Positive Employment Relations: International Experiences of Labour Management Partnership*, edited by A. Wilkinson and S. Johnstone. New York, NY: Palgrave Macmillan.
- Eaton, A. E., D. Konitsney, A. S. Litwin, and N. Vanderhorst. 2011. "The Path to Performance: A Study of High-Performing Unit-Based Teams at Kaiser Permanente." Kaiser Permanente Labor Management Partnership, February. <http://www.lmpartnership.org/rutgers>.
- Eaton, A. E., S. A. Rubinstein, and T. A. Kochan. 2008. "Balancing Acts: Dynamics of a Union Coalition in a Labor Management Partnership." *Industrial Relations: A Journal of Economy and Society* 47, no. 1: 10-35. doi:10.1111/j.1468-232x.2008.00502.x.
- Eaton, S. C., S. A. Rubinstein, and R. B. McKersie. 2004. "Building and Sustaining Labor Management Partnerships: Recent Experiences in the U.S." *Advances in Industrial and Labor Relations* 13: 137-56. doi: 10.1016/s0742-6186(04)13005-9.
- Institute for Healthcare Improvement. No date. "Reconcile Medications at All Transition Points." <http://bit.ly/2aolnsT>.
- Institute of Medicine. 2010. "ACGME Board of Directors Approved New Requirement for Residency Programs." Washington, DC: National Academies of Sciences. <http://bit.ly/29GD2aX>.
- Jaltenor. 2013. "Maimonides Residents Gain Notice for Medication Reconciliation." *CIR Vitals*, February 25. <http://bit.ly/29GD3LL>.
- Kochan, T. A. 2016. "The Kaiser Permanente Labour Management Partnership: 1997-2013." In *Developing Positive Employment Relations: International Experiences of Labour Management Partnership*, edited by A. Wilkinson and S. Johnstone. New York, NY: Palgrave Macmillan.
- Kochan, T. A., P. S. Adler, R. B. McKersie, A. E. Eaton, P. Segal, and P. Gerhart. 2008. "The Potential and Precariousness of Partnership: The Case of the Kaiser Permanente Labor Management Partnership." *Industrial Relations: A Journal of Economy and Society* 47, no. 1: 36-65. doi:10.1111/j.1468-232x.2008.00503.x.
- Kochan, T. A., A. Eaton, R. McKersie, and P. Adler. 2009. *Healing Together: The Labor Management Partnership at Kaiser Permanente*. Ithaca, NY: ILR Press/Cornell University Press.
- Lazes, P., M. Figueroa, and L. Katz. 2012. "How Labor-Management Partnerships Improve Patient Care, Cost Control, and Labor Relations." Washington, DC: American Rights at Work.
- Lazes, P., and J. Savage. 2000. "Embracing the Future: Union Strategies for the 21st Century." *Journal for Quality and Participation* 23, no. 4: 18-23.
- Litwin, A. S., and A. E. Eaton. Forthcoming. "Complementary or Conflictual? Formal Participation, Informal Participation, and Organizational Performance." *Human Resource Management*.
- Maimonides Medical Center. 2007. "Creating Competitive Advantage in a Changing Health Care Environment through Worker Participation: Strategic Alliance Report 2007." Brooklyn, NY: Maimonides Medical Center.
- Maimonides Medical Center. 2015. "Medical Education: Fellowship, Residency and More." Brooklyn, NY: Maimonides Medical Center. <http://bit.ly/29GNvmv>.
- Masters, M. F., R. R. Albright, and D. Eplion. 2006. "What Did Partnerships Do? Evidence from the Federal Sector." *Industrial and Labor Relations Review* 59, no. 3: 367-85.
- New England Organizing Project, no date. "About New England Organizing Project." <http://bit.ly/2aLjinA>.
- Patton, M. Q. 2002. *Qualitative Research and Evaluation Methods* (3rd edition). Thousand Oaks, CA: Sage.
- Porter, M. 2010 (Dec. 23). "What Is Value in Health Care?" *New England Journal of Medicine*, pp. 2447-81.
- Porter, M., and T. E. Lee. 2013 (Oct.). "The Strategy That Will Fix Health Care." *Harvard Business Review*, pp. 1-19.
- Preuss, G. A. 1998. "Committed to Care: Labor-Management Cooperation and Hospital Restructuring." Washington, DC: Economic Policy Institute. <http://bit.ly/29GOuDw>.
- Preuss, G. A., and A. Frost. 2003. "The Rise and Decline of Labor-Management Cooperation: Lessons from Health Care in the Twin Cities." *California Management Review* 45, no. 2: 85-106.
- Rubinstein, S. A. 2001. "The Local Union Revisited: New Voices from the Front Lines." *Industrial Relations: A Journal of Economy and Society* 40, no. 3: 405-35.
- Rubinstein, S. A. 2003. "Partnerships of Steel—Forging High Involvement Work Systems in the US Steel Industry: A View from the Local Unions." *Advances in Industrial and Labor Relations* 12: 117-46.