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## Emerging Model for Labor-Management Partnerships

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For the past decade, a number of unionized health care institutions have been experimenting with labor-management partnerships. Through our involvement in those experiments, and through our careful study of what others have done elsewhere, we can see the outline of a new model beginning to emerge that goes beyond joint problem solving, interest-based bargaining, and better labor relations to a more strategic alliance to radically transform the quality and cost of patient care.

In that new model:

- **The focus is on achieving excellence in the quality, safety and cost of patient care, not just better labor relations.** Since employees, clinicians, and managers all have a common interest in achieving the highest quality of care at the lowest possible cost, they have every reason to work together to make that happen. Ironically, better labor relations are easier to achieve and to sustain through joint efforts to get better results for patients than when pursued as an end in themselves.
- **Improvement efforts directly support the organization's overall strategy and performance objectives.** Joint efforts have the biggest impact when they focus on issues that are strategic to the organization as a whole, not just whatever problem is bothering people in the moment. For that to happen, everyone involved needs to be able to see the big picture of where the organization is headed, and get timely information on how the organization is doing on key measures of performance. Joint efforts that don't focus on strategic issues risk wasting valuable time and resources, including the energy and creativity of front-line staff.

- **Joint efforts need to involve physician leadership, not just management and unionized staff.** The involvement of physicians is critical to improving the quality and cost of care. But engaging physicians requires expanding the scope of the typical labor-management partnership structure. To be effective, the partnership structure needs to be interdisciplinary at both the unit/department and the institutional level.
- **Change starts at the point of care, not at the top of the organization.** Those on the front line of providing patient care are in the best position to initiate change. This runs counter to the conventional wisdom and prevailing practice in most organizations, which is that change starts at the top of the organization, then managers “roll it out” to the rest of the organization, using various techniques and gimmicks to get the staff to “buy in.” But those on the front line are in the best position to understand what patients need and what’s getting in the way of meeting those needs. They are also in the best position to know how the systems they work in really work, rather than how they are supposed to work or how others further removed from the day-to-day action would like for them to work.
- **The focus is on fixing broken systems, not isolated problems.** In making improvements, there is a natural tendency to try to isolate the problem, to define it narrowly, and to find a technical solution. Although that makes the problem easier to solve and the results easier to document, isolating the problem limits the impact of the change and makes improvements harder to sustain. Instead, the focus needs to be on where systems are breaking down or missing altogether. Managers need to follow these threads, and when they extend beyond the scope of an individual unit or department, they need to mobilize the appropriate people across departments and disciplines to address these systemic issues. That’s where the greatest leverage is for lasting improvements.
- **Spreading success requires networks, not cookie cutters.** Once a breakthrough is achieved in one area, the natural tendency is to mandate that everyone else adopt that practice. However, that approach tends to only provoke resistance. What works best is for those who made the breakthrough to share their story with others to demonstrate that a higher level of performance is possible and to educate others about what made it possible. Others can either apply the lessons learned by the pioneering group or come up with a better approach of their own, creating the possibility for additional breakthroughs.

We've observed that there are a number of advantages to this approach:

- **This approach doesn't involve rolling out big initiatives hospital-wide, which is very labor intensive and often provokes a lot of resistance.** Involving the front-line staff creates energy and ownership for making needed changes. Since most systems extend across units and departments, a breakthrough in one area can pave the way for similar breakthroughs in other areas, as superior results attract interest and inspire imitation. This makes it possible to start small and grow at a pace that can be supported by available resources.
- **This approach doesn't necessarily require a lot of up-front training, or time away from patient-care responsibilities.** Most training can be done "just in time" as the need becomes apparent. And because the focus is on taking action to make improvements at the point of care, not sitting in meetings, most of the activity can take place in the unit or department.
- **This approach doesn't necessarily require that new meeting or committee structures get overlaid onto existing structures, creating more complexity to manage.** Instead, the focus is on building the capacity of existing structures to do this work, which makes it easier to make and sustain improvements.
- **This approach doesn't necessarily require hiring a lot of new staff.** Fixing broken systems can free up the current staff to spend more time with patients, further improving the quality of care and staff satisfaction without additional staff. However, in situations where chronic understaffing is creating constant turmoil and crises, it may be necessary to add some staff initially to stabilize the system enough to improve it.