

■ COMMENTARY

# The Case for Unit-Based Teams: A Model for Front-line Engagement and Performance Improvement

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## Abstract

Unit-based teams (UBTs)—defined as natural work groups of physicians, managers, and frontline staff who work collaboratively to solve problems, improve performance, and enhance quality—were established by the 2005 national agreement between Kaiser Permanente (KP) and the Coalition of KP Unions. They use established performance-improvement techniques and employee-engagement principles (including social-movement theory) to achieve clinical and operational goals. UBT members identify performance gaps and opportunities within their purview—issues they can address in the course of the day-to-day work, such as workflow or process improvement. By focusing on clear, agreed-on goals, UBTs encourage greater accountability and allow members to perform their full scope of work. UBTs are designed to deliver measurable benefits in clinical outcomes and operations, patient-experience enhancements, and physician-team performance or work life. For many physicians, UBTs will require new ways of engaging with their teams. However, evidence suggests that with organizational and physician support, these teams can achieve their goals. This article presents case examples of successful UBTs' outcomes; physicians' comments on their experience working with teams; an overview of UBTs' employee-engagement principles; and advice on how physicians can support and participate in the work of such teams.

Early in 2008, the Internal Medicine team at the Kaiser Permanente (KP) facility in Strongsville, OH, lost three of its five clinicians. It was struggling to maintain access and patient flow, much less increase its focus on chronic-care management. Yet within six months, the team stepped up patient education, improved its workflow, and increased from 62% to 74% the number of diabetes patients with cholesterol

levels under control, surpassing the Region's goal. A medical-surgical unit at Fontana Medical Center, in Southern California, went 23 consecutive months, until January 2010, without an incidence of hospital-acquired pressure ulcers, after previously reporting seven to ten cases a year. Colorado's regional laboratory improved the accuracy of its transfer and tracking records from 90% to 98%, significantly reducing rework

and speeding turnaround times for patients' laboratory test results. These outcomes, and hundreds of others across KP, were the result of performance-improvement projects undertaken by Unit-Based Teams (UBTs)—KP's strategy for frontline engagement and collaboration (See Sidebar: About Unit-Based Teams).

Physician involvement in UBTs to date has varied and generally remains limited. However, in view of evidence from across KP, we believe that UBTs can help physicians achieve their clinical goals and improve their efficiency and thus deserve their broader involvement.

## How Unit-Based Teams Work

UBTs apply their skills to better serve patients and address the needs of the unit, much as the best teams always have in the Permanente model of care. However, UBTs differ from most existing work units by:

- Identifying specific areas for improvement consistent with department or regional goals
- Using well-established performance-improvement techniques<sup>3</sup>
- Measuring and assessing their results
- Having joint leadership by physicians, managers, and union workers.

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### About Unit-Based Teams

Unit-based teams (UBTs) were established by the 2005 national agreement between Kaiser Permanente (KP) and the Coalition of KP Unions. They are defined as natural work groups of physicians, managers, and frontline staff who work collaboratively to solve problems, improve performance, and enhance quality for measurable results.

Typically, a UBT comprises all members of a work unit or module. However, large groups—such as regional laboratories or call centers—may use a representative model, in which union-represented staff select their own delegates, often the shop steward. Most UBTs meet at least once a month to identify problems, review their progress, and plan future tests of change. Many teams meet more frequently in quick huddles. Physicians participate as needed.

UBTs are designated by regional and facility leaders and receive performance-improvement training and support. As of February 2010, more than 2600 UBTs representing more than 82,000 employees and physicians were operating across KP. The goal is for 100% of staff represented by the union coalition to be working in UBTs by the end of 2010.

UBTs advance and align the work of the unit with the clinical and business goals of each Region. Teams identify performance gaps and opportunities within their purview—issues they can address in the course of the day-to-day work, such as workflow or process improvement. By focusing on clear, agreed-on goals, UBTs encourage greater accountability and allow team members to fulfill their full scope of practice or job description. Achieving agreed-on goals, in turn, promotes continuous learning, productive interaction, and the capacity to lead further meaningful change (See Sidebar: Principles of Employee Engagement).

As a strategy for process and quality improvement, UBTs draw on the study of “clinical microsystems,” advanced by organizations including Dartmouth-Hitchcock Medical Center and the Institute for Healthcare Improvement (IHI).<sup>1,2</sup> Donald Berwick, MD, President and Chief Executive Officer of the IHI (nominated by President Obama in April 2010 to head the Centers for Medicare & Medicaid Services), has

recognized UBTs as a source of organizational innovation: “If we want to optimize a system, it’s going to be around teams and teamwork, and it’s going to cut across hierarchies and professional norms. UBTs and much better relationships between those who organize systems and those who work in the systems are going to be essential ...”<sup>3</sup>



Figure 1. The Kaiser Permanente Values Compass.

Most improvement projects fall under one or more points of the KP Value Compass, with the patient and member always at the center (Figure 1). Outcomes from teams across KP include the following:

- Improving clinical quality through better follow-up practices or proactive office encounters

- Increasing patient satisfaction as measured by patient-satisfaction survey scores
- Improving turnaround times for laboratory and diagnostic imaging results
- Eliminating unnecessary costs or waste
- Reducing patient wait times or delays
- Reducing process work-arounds, rework, and non-patient-driven variation
- Reducing workplace injuries, as measured by accepted Worker Compensation claims.

Information about UBT outcomes in specific KP Regions may be obtained by contacting the Labor Management Partnership coleads in specific Regions or facilities.

### Four Key Benefits

The focused nature of UBT activities translates to four broad benefits to physicians and patients:

- *Clinical benefits:* Saving lives and improving health
- *Operational benefits:* Using resources wisely and improving efficiency
- *Member and patient benefits:* Providing a great patient-care experience
- *Physician-team benefits:* Improving team performance and work life.

The examples that follow show how UBTs in different Regions have delivered one or more of these benefits.

### Clinical Outcomes: Controlling Hypertension

The Internal Medicine Department at Hill Road Medical Offices in Ventura, CA, faced a practical challenge: Patients with an initial elevated blood pressure reading

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had to be retested after waiting at least two minutes—but they often left the office before the staff could do a second test. In fact, staff were doing needed second checks only 26% of the time as of March 2008.

Hill Road’s team brainstormed ways to do better. Their simple solution: a bright yellow sign reading, “Caution: Second blood pressure reading is required on this patient,” which employees hang on the examination-room door so that the physician or staff would be sure to do the test. “This was a ‘try-out mode,’” says Prakash

Patel, MD, “and now the results are much better. The teams come up with good ideas about workflow because these are the folks in the trenches, and they see the headaches. They share ideas and work out processes that help.” In just one month, the department’s score on giving second blood pressure tests was 100%. The department’s score on the regional clinical goal of hypertension control went from 76% in August 2008 to 79.8% in May 2009, just below the regional goal of 80.1%. The team earned a Distinguished Accomplishment Award from the Region.

**Operational Benefits: More Responsive Patient Service**

Until recently, most staff at Colorado’s Telephonic Medicine Center were scheduled to work during the day, Monday through Friday—but 70% of the department’s calls came after 5 pm and on the weekends. Patient access and satisfaction was poor as a result.

By being flexible, putting the members’ needs first, and using their problem-solving training, the team devised solutions. They agreed that all the nurses—even the most senior—should work

**Principles of Employee Engagement**

Unit-based teams (UBTs) draw on well-established principles of performance improvement and employee engagement. Their use in health care settings is supported by the study of “clinical microsystems” by Dartmouth-Hitchcock Medical Center, the Institute of Healthcare Innovation, and others.<sup>1-3</sup> In addition, exchange visits with the high-performing health care system of Jonkoping (Sweden), academic studies of workplace performance, and years of union experience mobilizing health care workers regarding workplace change all inform the theory and practice of UBTs at Kaiser Permanente (KP).

**Impact of Engagement**

Professor Jeffrey Pfeffer of the Stanford Graduate School of Business has reported that “[i]n hospitals, [the] benefits of collective bargaining clearly improve the quality of patient care ... [but] much of that gain disappears when labor-management relations become adversarial.”<sup>4</sup>

Thomas A Kochan, a labor economist and professor at MIT Sloan School of Management, has studied KP’s Labor Management Partnership from the beginning. He and his research team concluded that “UBTs open the organization to a variety of process innovations that can improve efficiency, quality, and patient satisfaction through changes to operational policies.”<sup>5p202</sup>

In their assessment of 15 units in KP’s Northwest Region, the researchers compared units with different levels of employee involvement in Labor Management Partnership activities, determined from annual employee survey findings, and reviewed clinical outcomes in five areas: adult immunization, breast cancer screening, lipid screening, asthma monitoring, and child immunization. They found that all five clinical outcomes improved with more partnership involvement.<sup>5p206-9</sup>

High employee engagement translates to high performance in other

ways as well. Studies by human resources consultants Watson Wyatt (now Towers Watson) have shown that highly engaged employees are twice as likely to be top performers, exceed performance expectations in three-quarters of cases, and more readily identify with the organization and its customers.<sup>6</sup>

Team-performance assessments at KP have found similar connections. “We’re still collecting the data, but in my experience, teams that have highly engaged workers and good team dynamics are twice as likely to be top performers,” says Paul Staley, Vice President, Operational Initiatives and Performance Improvement, Office of Labor Management Partnership. “They tend to score higher on performance metrics across the board.”

In addition, past studies found that employee attitudes about work were linked to members’ attitudes: Studies in Ohio, Georgia, and the Northwest showed that in locations where KP employees said they

	Voluntary	Compelled
External	<ul style="list-style-type: none"> <li>Benchmarks</li> <li>Learning from best practice</li> <li>Patient experience</li> <li>Partnership working with the wider health and social care community</li> <li>Best practice from the NHS Institute for Innovation and Improvement</li> </ul>	<ul style="list-style-type: none"> <li>Performance targets</li> <li>National quality standards and frameworks</li> <li>Patient choice</li> <li>Working agreements for doctors and other staff</li> <li>Adverse events</li> <li>Service reconfiguration</li> </ul>
Internal	<ul style="list-style-type: none"> <li>Ambition beyond national targets</li> <li>Leadership systems</li> <li>Clinical leadership and engagement</li> <li>Patient partnership</li> <li>Internal improvement methods</li> <li>Investment in training/development</li> <li>Culture of innovation</li> </ul>	<ul style="list-style-type: none"> <li>Performance management</li> <li>Internal patient safety standards</li> <li>Measurement systems</li> <li>Clinical standardisation</li> <li>Clinical pathways</li> <li>Financial control</li> </ul>

Figure 2. Traditional change efforts. NHS = National Health Service.

one weekend shift or both weekend days every other week. The nurses were able to pick their shifts according to seniority. Average patient callback times on the weekends decreased from 37 to 17 minutes. Patient and employee satisfaction significantly improved as a result. For instance, the percentage of staff who said the department usually had enough people to do their job right increased from 29% to 65%. Full team engagement made the difference. “We just wanted to be able to express ourselves and be heard,” says Janet Jackson, RN.

“Sometimes, that’s all it takes.”

Another Colorado UBT, in Skyline Medical Center’s Internal Medicine Department, developed a hypertension clinic to allow patients to be seen more quickly, without having to schedule a full appointment with a physician. Sean Riley, MD, coleader of the team, says of his involvement, “It’s benefited me and my patients, and it frees up some of my time to deal with different types of patient-care issues. It helps facilitate communication and understanding about what everybody’s role is in terms of running the clinic.”

### Physician-Team Benefits, Member and Patient Benefits, and Operational Benefits: Improving Attendance, Safety, and Service

For years the Adult Medicine Department at Walnut Creek Medical Center in Northern California struggled to provide a great patient experience. Attendance was poor. The rate of workplace injuries was high. Patients were often roomed late, causing headaches for physicians and patients.

In 2007, department managers and union stewards resolved to

would recommend KP as a good place to get care, Health Plan members themselves were more likely to recommend KP to others or were more likely to give more favorable patient-satisfaction scores.<sup>7</sup>

### What Drives Change

Helen Bevan, Director of Service Transformation, National Health Service (NHS) Institute for Innovation and Improvement, has used social movement theory to lead major performance and service improvements at NHS. Bevan has observed several characteristics of traditional workplace change efforts.<sup>8</sup>

Most change efforts she observed at NHS and elsewhere have focused on the upper right-hand quadrant of Figure 2—compelled effort, driven from outside (and usually above) the work unit. These are necessary elements, says Bevan, but not enough to change people’s attitudes, energy, and level of commitment. What is also necessary but often missing, she

found, is an environment of internally driven, voluntary effort (Figure 3). “The health care revolution begins with each of us starting to think differently about our role as a leader in change,” says Bevan. ❖

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Figure 3. Transformation change efforts. NHS = National Health Service.

work together as a UBT—and the Department Chief, Helge Johannesen, MD, asked to be part of it. He suggested that a medical assistant assigned to each of the four stations in the unit select a physician with whom to identify problems and test solutions. “The physicians were happy to be involved,” says Dr Johannesen.

**Physicians still set the tone and lead by example. Staff will model their behavior after physicians.**

To help room patients on time, staff started and ended their lunch break ten minutes earlier. The change was piloted at one station at a time, to give others a chance to assess results and buy in. In addition, the team developed a proposal to reconfigure the floor plan, consolidate member check-ins at one station, and provide more flexibility. To improve attendance, staff agreed on schedules and ensured that time-off requests were covered. Sick days dropped from more than nine days per full-time employee in 2007 to 7.35 days per year in 2008—well below the regional target. The team ended 2009 with just 2.8 days of sick time per full-time equivalent, no missed meals or breaks, and no workplace injuries. New scheduling processes also allowed the unit to book patient appointments sooner. Member and patient satisfaction scores have increased along with team performance.

“The UBT worked much better than I expected,” says Dr Johannesen. “There’s more of a give-and-take, and we can better see the big picture.” He adds that working with the UBT has helped him achieve department goals and has given other physicians new leadership experience. “We get better solutions and more support from the people who can ensure that changes we discuss actually happen.”

### How Physicians Can Lead

For many physicians, UBTs will require new ways of engaging with their teams. UBTs may at first struggle with how to be productive and where to focus their efforts (See Sidebar: How to Choose an Improvement Project). But some things will not change:

- Physicians still set the tone and lead by example; staff will model their behavior after physicians
- Physicians are still responsible for leading the team and making the clinical and quality decisions. The team will work with the physician to make decisions on work flows to support the care experience and outcomes for patients and patients’ families.

It may take time for teams to become proficient in problem-solving techniques, just as it takes time to master a new clinical technique or procedure. Strong team leadership helps speed the transition from dwelling on process (how to make decisions and handle disagreements) to getting results for

patients and enhancing the work experience for staff, managers, and physicians.

UBTs are taking hold at the right moment for KP. Clinicians are under pressure to contain costs, maintain quality, and improve service, and UBTs have the problem-solving tools to address those issues. Furthermore, research shows that when physicians and patients communicate well, patients are more likely to adhere to therapeutic regimens, are more satisfied with office visits, and have better outcomes.<sup>4</sup> Additional research shows that when members of the support staff feel respected and valued by the physician, patients have better perceptions of the physician.<sup>5</sup>

Physicians can do many things to support and benefit from the work of their teams: listen openly to the comments and suggestions of nonphysicians; give feedback in a spirit of mutual respect, collaboration, and learning; participate in UBT huddles and improvement efforts; and recognize team members’ contributions.

### How to Choose a Performance-Improvement Project with Your Team

As unit-based teams (UBTs) spread across Kaiser Permanente, physicians can do several things to support their development and reap the benefits. One key to getting a high return from the time invested in a UBT is to select appropriate performance-improvement projects. An effective effort should be:

- Something everyone cares about and demonstrably improves patient care, service, or affordability
- Consistent with the regional or medical center priorities (eg, better control of hypertension or diabetes, better service scores)
- Within the scope of the unit—something the unit can do without another unit’s cooperation
- Small enough to achieve in a reasonable time frame—but important enough to be interesting and relevant
- Measurable, preferably using data you already have or can readily collect
- Helpful to the team and its relationships, building the capacity to take initiative, be creative, and put patients first.

“I strongly encourage all chiefs of service to champion the unit-based team in their department by either active participation or as a physician advisor, particularly regarding quality, service, and access initiatives,” says Virginia L Ambrosini, MD, Assistant Executive Medical Director, Permanente Human Resources, Southern California Permanente Medical Group.

The best UBTs make demands on all members of the team, including physicians. However, as UBTs grow in number and proficiency, so does the evidence base: UBTs are getting measurable results, improving care and service to KP patients, and strengthening the KP model of care. *A 30-minute physician training program on UBTs (“Orientation to Unit-Based Teams Web-based Training for Physicians”) is available online at KP Learn (<http://learn.kp.org/> [registration required]).* ❖

<sup>a</sup> The Rapid Improvement Model, based on a framework developed by Associates in Process Improvement and popularized by the Institute for Healthcare Improvement, uses iterative cycles of “plan, do, study, act” to conduct small tests of change

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## Play Together

The way a team plays as a whole determines its success.  
You may have the greatest bunch of individual stars in the world,  
but if they don’t play together, the club won’t be worth a dime.

— Babe Ruth, 1895-1948, American baseball player