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Thought Leader Forum

Discussion Transcript

The Role of Health Care Human Resources in Advancing Operational Efficiencies and Effectiveness

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ashhra
AMERICAN SOCIETY FOR HEALTHCARE HUMAN RESOURCES ADMINISTRATION
OF THE AMERICAN HOSPITAL ASSOCIATION

Founded in 1964, ASHHRA is the leading voice for HR professionals in health care - linking people and organizations to leadership practices, best practices to patient outcomes, and outcomes to business results. Headquartered in Chicago, IL, the society has more than 3,400 members and services the needs of over 50 chapters throughout the United States. For more information about ASHHRA, visit www.ashhra.org.

Vision

By joining together, by raising our skills and by speaking with one voice, we, as ASHHRA members will enhance the well-being of our employees, our health care organizations, and the communities we serve.

- ***Our purpose***: To establish the expertise of health care HR through our ability to learn and share knowledge, build relationships, and exemplify excellence.
- ***Our power***: To influence and impact the future of the health care workforce and those they serve.
- ***Our promise***: To keep in our minds and hearts the passion and commitment we have for our profession.

Mission

ASHHRA leads the way for members to become more effective, valued, and credible leaders in health care human resources administration.

Guiding Principles

Collaboration * Service Excellence
Integrity * Innovation * Passion

Value Proposition

We offer high quality and effective resources, educational programs, and networking opportunities to human resources professionals in the health care industry.

Introduction

The American Society for Healthcare Human Resources Administration (ASHHRA), a personal membership group of the American Hospital Association (AHA), held its third Thought Leader Forum on Thursday, July 23, 2009 in San Francisco, California, prior to the 2009 AHA/Health Forum Leadership Summit.

Jeanene Martin, Senior Vice President, Human Resources, WakeMed Health and Hospitals, and ASHHRA immediate past president, chaired the proceedings. The discussion was moderated by Larry Walker, president of The Walker Company Healthcare Consulting.

A select group of health care professionals participated in the Forum, a two-hour session titled "The Role of Health Care Human Resources in Advancing Operational Efficiency and Effectiveness."

"I think about our role as a professional society here. At the time when people question the value of pretty much everything they do, certainly the professional organization work that you all did today, the kind of thought leadership that we heard today will help our members," said ASHHRA president Dan Zuhlke. "It is a time for all of us to be courageous, to think about redefining our role and not letting someone else redefine it for us. It is a great time for HR professionals. Our industry is at an exciting point, and we need to look at this as an exciting challenge."

This Thought Leader Forum report is an edited transcript of the Forum conversation. The *Summary of Findings*, an executive summary of the Thought Leader Forum, can be found at www.ashhra.org.

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The Role of Health Care Human Resources in Advancing Operational Efficiency and Effectiveness

This report on the role of health care human resources in advancing operational efficiency and effectiveness is based on a *Thought Leader Forum* discussion with prominent hospital and health system human resources executives, members of the American Society for Healthcare Human Resources Administration (ASHHRA) board of directors, and other experts, held on July 23, 2009 at the San Francisco Marriott Hotel in San Francisco, California. Participating in the *Thought Leader Forum were:*

Jean Chenoweth
Sr. Vice President
Thomson Reuters Healthcare, Ann Arbor, Mich.

Martin Fattig
CEO
Nemaha County Hospital, Auburn, Neb.

Randy Fuller
Director, Thought Leadership
Healthcare Financial Management Association, Westchester, Ill.

Jeanene Martin
Sr. Vice President, Human Resources
WakeMed Health and Hospitals, Raleigh, N.C.

Jeff Payne
Vice President, Human Resources
Lakeland Regional Medical Center, Lakeland, Fla.

Molly Seals
Sr. Vice President, HR & Learning
Catholic Health Partners Eastern Division, Humility of Mary Health Partners, Youngstown, Ohio

Dan Zuhlke
Vice President, Human Resources
Intermountain Health Care, Inc., Salt Lake City, Utah

Lynn Dragisic
Vice President, Human Resources
The Joint Commission, Oakbrook Terrace, Ill.

Jill Fuller
Chief Nursing Officer
Prairie Lakes Healthcare System, Watertown, S.D.

Donna Herrin
Clinical Associate Professor
The University of Alabama Huntsville, Huntsville, Ala.

Bob Morrison
President and CEO
Randolph Hospital, Asheboro, N.C.

Lisa Schilling
Vice President, Healthcare Performance Improvement
Kaiser Permanente, Oakland, Calif.

Deb Stock
Vice President, Member Relations
American Hospital Association, Chicago, Ill.

Larry Walker, President, The Walker Company Healthcare Consulting, moderated the Thought Leader Forum discussion. This report is an edited version of the transcript of the discussion.

Larry Walker: ***Welcome to this third ASHHRA Thought Leader Forum focusing on the role of health care human resources in advancing operational efficiencies and effectiveness. This is one of the foremost challenges facing every hospital in this country today, and we're looking forward to a very lively, rich and robust dialogue on this topic.***

We'll talk about what we mean by efficiency and effectiveness. We use those words together all the time, but they don't share the same meaning. We'll explore what you see as some of the root causes of inefficiency, and ways that HR leaders can contribute in a meaningful way to addressing those. And we will explore some of the areas that you think have the greatest potential for improving efficiency and operational effectiveness in America's hospitals and health systems.

With that introduction, let me begin by asking what you see as the difference between operational efficiency and operational effectiveness? How do they differ?

Lynn Dragisic: When I think about efficiency, I think about bringing the right people together, the right processes and the right technology together so they enhance the quality and productivity of business operations. Effectiveness means it's working. We can use a number of process improvement methodologies, but if we don't have accountability or acceptance by the employee population, we might not be optimally effective.

Molly Seals: I definitely agree that effectiveness is all about the end result. It's about the outcomes, and having the right care at the right time, with the right patient and with the right result. Efficiency to me is all about removing the waste. It's taking out those extra steps that the nurse needs to take to get the supplies and the equipment that she needs to do the job. It's about removing the extra paperwork that is a burden on the health care system, and that gets in the way of spending time with the patient. One is about the end results and the right results, and the other is just about removing waste, and making processes as streamlined as possible so that individuals can do their work in less time, for less money and with less effort.

Marty Fattig: Efficiency is about management. Effectiveness is about leadership. Efficiency is about doing things well and effectiveness is doing the right things. We can be extremely efficient at doing the wrong things, which gets us nowhere.

Donna Herrin: I hear us already in the definitions here using terminology like "the right things." I would say that the entire industry needs to really rethink what the "right thing" is. It's a question about how we think we are doing the right thing for patients, populations and communities. But what is right? I think that we are about to see that conversation go to an entirely different level, because for what we think may be the right thing to do today, there may be no evidence base, or maybe its not in alignment with the receiver of care's beliefs. Maybe in the end it doesn't produce an outcome that is desirable by the one who receives it. I think we are going to see that conversation go to a completely different place.

Jill Fuller: We ask, would the patient pay for this? Would the patient pay for the committees that we have in our hospital? Would they pay for our overhead? That is part of what I think you are saying, Donna, in terms of what our consumer wants. We have a lot of waste in our system in the things that we've created.

Lisa Schilling: You know, some of the things that we talk about, in particular around effectiveness, depend on whose lens we are using. If we use the patient's lens, the conversation for us changes. We think effectiveness is using all of the evidence-based practices to get the best health outcomes. However, when we put the patient in the mix, they say, "I don't want to have to come back three times. Can I do this all in one visit?" How can we be efficient and effective at the same time? I think the patient's lens pulls both definitions together.

Lynn Dragisic: That's the voice of the customer, and we have to consider who our customer is. Internally, of course, we have customers and employees. A number of things that we do from a human resources perspective, in terms of making employees effective and committed, very much depends upon listening to their voice. The voice of the patient is a different customer. I think we have to listen to a variety of voices and try to come up with the right solutions.

Walker: ***We know that HR touches every system, every process, and every person in the organization. What do you see as some of the root causes of process or system inefficiency that HR leaders are ideally positioned to be able to address?***

Bob Morrison: I think HR leaders are going to have to adapt. HR leaders are often unprepared for what their organizations need right now. Going back to the question of the difference between efficiency and effectiveness, we are very poorly equipped as organizations to decide what is effective. We have an "expert culture," with physicians using the most expensive piece of equipment in the hospital, a ballpoint pen, to write orders that spend money, to tell other people

what to do based on a craft mentality that one person is supposed to know enough to make all of those decisions.

And the expert culture exists at other levels, too. There is a nursing culture, a pharmacy culture, every profession has its cubby hole and area of expertise that nobody else challenges. We need to be able to sit down around a table, in an environment where people are competent to know what a process is, and to talk to each other about it, and speak the same language about a process, and then ask what the care process is. Then everyone needs to be bound by the decision that the group makes.

As we think about the resources we need and people critical to it, I think some of the questions for human resources will be, "How do we participate in the selection and development of people who can participate in designing processes? How can we help create an environment where once the decision is made, the attitude is How can I help? I think while we have been focused on a lot of important things in human resources, one of the things we need to talk about more in the future is how we select and orient people, and bring them into an organization so that they are prepared to make decisions on a team basis, and work together successfully?

Randy Fuller: I think we are the victims of processes that have been cobbled together over many, many years. When we are faced with problems, at least in my experience, it has typically been that we have cobbled together a work-around rather than solving the root cause, and getting at the actual issue of the problem. The result is that we now have a field that is not designed as a nice, straight pathway. It's just a cobbled system of procedures. Those problems would be more solvable if people had been engaged together as a team.

Dan Zuhlke: The next great challenge for HR leaders is to take on the role of being the champion for organizational effectiveness. For many years we've done all of the traditional HR work, and in many cases we can now contract that work out. But I think our next biggest challenge is to understand organizational effectiveness, and how all these pieces interrelate and ultimately lead to the best outcomes for our patients and our communities.

Our challenge as HR leaders is to first of all understand all of the components within our organizations, understand how they fit, and understand what role we play in either delivering on our specific challenges or pushing others to make sure that we are looking at how things fit, and what outcomes those things are producing. We may not have the skills across the country to do that today, but as we do more work like this, I think we need to position HR leaders in their organization to be the "go-to" people that really drive organizational effectiveness, because we see the whole picture.

Jeanene Martin: Lynn touched on the right people doing the right work. I think that is where HR can play a tremendously important role. Over time, certainly in our system, we hired higher level people to do work that probably someone at a lower pay grade could do, may be happier doing, and may be able to do more efficiently and more effectively. I think that that is a role that we as HR professionals have. Perhaps it's time to sit down with our nursing leaders and our clinical leaders and talk about our job descriptions and whether the right individuals are delivering the work that needs to be provided.

Deb Stock: Back to the issue of teamwork, I think that going forward that is going to be absolutely key for a number of reasons. We are not going to have the numbers of staff that we need at all levels, physicians, nurses, and others. The care is becoming more and more complex. It's moving out into other settings, and we need to redesign the work so that we have a variety of teams operating as efficiently and effectively as possible. Unfortunately, health professions don't know how to work well as teams; they are educated in silos; it's not a natural thing for them to work together. Much of the care right now is organized in such a way that it is very silo-based, and I think that, in particular, is an area where HR leadership can facilitate progress.

Donna Herrin: I wanted to go back to that point as well, to highlight why this is so complex. We have to help with the transformation that is happening today, get teams to work better together, facilitate the right people at the right spot with the right team attitudes, and then look at more of a medium-range strategy. How do we implement improvements that are a little broader and larger before we get to a real system transformation? I think we need to make a radical change in the way that the care process works, how people come together to provide care, and move to team roles where hierarchy is not in the way. What we see too much of right now are a lot of little "tweaks" to systems and to teams. It's just dabbling around the edges, and we really haven't seen a real radical transformation, which is what I think has to happen.

Jill Fuller: I'd like to give you an example of a radical transformation that involved HR and frontline managers. We eliminated annual individual performance reviews. We did it for a couple of reasons. Health care is a team sport, it's not an individual performance sport. Now, you may have individual performance issues that have to be addressed, but it is a team sport, and we evaluate performance by looking at fall rates and errors, things like that, not by looking at individual performance factors. Managers want time to coach teams, and we said to our managers "what bogs you down?" They said, "Completing all these performance reviews on 70 some people in my department." HR became the compliance cop, and they couldn't coach managers and develop managers because for HR, success was if all of the reviews were done on time and in the file. So we eliminated evaluations, and the world has not come to an end.

The role of HR is to try to develop an embedded performance management system, teach managers how to hire right, and teach managers how to be coaches. Managers now have more time because they're not bogged down by bureaucracy and paperwork. I think that is a radical transformation that sometimes kind of shakes people up, but that's the kind of change we have to make.

Walker: ***Jill, have you been doing that long enough in your organization to have a sense of the outcomes?***

Jill Fuller: We started and piloted it on a medical-surgical unit, and probably have been doing it for a year and a half now. I think our managers are better at progressive discipline, because they can focus on that now. I think morale is up, because managers are engaged with staff in terms of coaching. We had to have a compensation system that would support that. We don't pay based on performance or merit. We pay based on market, which is much more satisfying to our staff. I think we have better morale because we don't have that system in place anymore. Our old system didn't add value to the employees, to the managers or to the organization.

Lisa Schilling: The point of transformation and moving from the craft of medicine to what we're starting to talk about, which is a system of care, is leadership. All too often we promote people through the ranks because they're really good at their craft, and they have the respect of their peers, but we don't give them the tools and the skills to really lead into the future.

Dan Zuhlke: We have a lot of discussion about the nurse manager role. Over the years, we still call the job the same thing; we still have the same expectations. But these people are managing large units of people, and we expect so much and provide too little to prepare them for that. It's key for us to really be able to be more effective and more efficient, and it doesn't just happen. It's hard work that we need to take on, and figure out how we provide the resources, how we provide the support and how we prepare a group of people to manage a unit of 150 people that are half part-time, some per diem, etc. It's just the hardest job I know.

Donna Herrin: The nurse manager role in health care organizations in any other industry would be the CEO of a small business, with multi-million dollar budgets and teams of over 100 people. We don't really treat that role with the accountability, support, training and education that are needed. The other point I want to make is that organizations like AONE, ASHHRA and others have programs that can be shared. For instance, AONE has the Aspiring Nurse Leader Institute, the Nurse Manager Fellowship, and Essentials of Nurse Manager Orientation programs. Collaboration among our professional associations is incredibly important. It's important to share the resources we all have, because we sometimes have a tendency to focus on what we're lacking rather than the abundance we have.

Lynn Dragisic: Some organizations, especially large organizations, don't share across the organization, and that's unfortunate. One of the things that we're trying to do, and we're a smaller organization, is build "leadership blueprints." We have a professional development center that focuses on a learning culture, not necessarily a training culture. What we're doing is identifying the exposure you should have if you're an emerging leader. Some of them will be classroom exposures, some might be online exposures, and some might be mentoring that you receive. I think that having a structured approach, thinking through with people across the organization, and having tools available across the organization is very helpful and efficient.

Jeff Payne: I'd like to go back to the original question of effectiveness: how you measure effectiveness and how key that is to the organization. I think you said earlier, Lynn, that the greatest opportunity in becoming more effective is with what we already have. Certainly, the health care delivery model is undergoing traumatic change, and over the next 10 years will certainly look very different. We need to ask, "how do we do things better, how do we do things differently?" Our CEO often cites Indianapolis Colts coach Tony Dungy's book about no excuses: just do what you're supposed to do. If we have the managers, if we equip them and train them, they still have to do what they said they were going to do.

Our nurses at the bedside know exactly what a great nurse will do to help make sure that patient has the best experience. Will they do it consistently? Will everybody across the board? Will HR do its thing consistently? And the answer is mostly. But we have opportunities, and I think HR is one of our grand opportunities to continue to help our organizations hardwire in accountability and create a line system that

rewards those who understand and do their jobs well.

We hire about 600 people a year, and we receive about 3,000 applications a month for employment. We do a lot, and we do it well, but who goes back and says "Was that personnel file created accurately? Was that paycheck?" Our self-auditing is not real good, because we assume we know the job and we're doing it, but who's looking behind the scenes? I think if we really spend the effort to hold ourselves accountable and look at the outcomes of what we are doing, we will find lots of opportunities to do it better, which would by definition, in my mind, increase efficiency.

Jean Chenoweth: I find what you said absolutely fascinating. When I was asked to come here, one of the things that struck me was that HR has been almost absent from the measurement of the performance of the organization, except for the 100 top hospitals. When we compare top hospitals to average performing hospitals, one of the most significant differences is that the top performing hospitals have HR as a part of the senior team. Another observation is that I don't think we have evolved in facilitating measurement tools for HR to actually measure what the impact has been. I've learned that the measurement of engagement is key, but does that relate back to quality of care and productivity? I think those are new areas to explore.

Jeff Payne: Yes, absolutely. We've used Gallup for measuring engagement, and they can definitely show the correlation in patient outcomes with engagement. They have the data to back it up, but the question is as we do things in hospitals, who is asking HR what the return on investment is on a new program? We layer on IS systems, and we say, "This will result in increased or lower FTEs", or increased whatever. But three years later, who is measuring if that actually happened? What tends to happen is that we just layer it in, and we tend to build without the back side analysis. That's the debate we're having in our organization right now: who is holding whom accountable?

Bob Morrison: I think as we put those kinds of systems in place, we use them as ways of making the things we have always done more efficient. Something you said, Jeff, really jumped out at me a second ago when you talked about people knowing what to do, but do they do it? As we did some of our work early-on in quality, we found that when patients didn't get what we thought they should get, when we thought they should get it. The two most common reasons were, "I didn't know" and "I forgot." We were depending on physicians or nurses who might take care of patients with 40 or 50 different diagnoses, of different ages, different kinds of health conditions affecting them, different allergies and other kinds of situations, to remember everything. As complex as our hospitals are, we have to understand that no one can remember everything. We have to get away from that "expert culture." And here I want to draw a distinction between two words: communication and teamwork. We do a lot of communication around variances; we don't do enough on teamwork, which is where we decide before the patient ever arrives how we are going to do things. That's my definition of teamwork.

The Chief Executive Officer and the Chief Human Resource Officer have got to get on the same page and talk about these things and say, "What's it like to work in this organization? Is it okay if people don't wash their hands? If it isn't okay, why are there so many people that don't? It must be OK, because we're getting 94 percent compliance when we work on it really hard?" As one of our consultants put it the other day, is it okay with you if when your pilot is landing the plane, 94 percent of the time he puts the landing gear down before the plane hits the runway?

Lisa Schilling: I believe a fundamental HR job is understanding what a "just culture" is. The person who walks into the patient's room doesn't want to hurt the patient. They are actually trying to do work-arounds to make sure the patient is safe and well cared for, and it's that individual performance, that heroic performance that saves that patient from harm. It's our job to have a system. What is the play-book? Is the play-book the same no matter where you are?

Number two, who is supporting that play-book? Who's going to come


Jeff Payne

in and support that nurse for stopping that physician from carrying out in a procedure because he hasn't done the right things right? When he or she stops that person, they have to be supported, and that's the just culture. In our organization we looked at sentinel events, and what happened after sentinel events. We're pretty large, so we have lots to look at. What we found was that every time something bad happened to a patient, the nurse got counseled. We saw this time and again. We said, "Isn't this the definition of insanity, that the nurses are getting counseled, when it seems like it's a system issue?" What are we going to do to, one, boost the culture and make it okay to raise the issues and stop the line; and two, create systems that are safe for the staff to work in so that they don't have to be that heroic person every day?

Marty Fattig: Leadership has to set the tone of what is acceptable and what is not. One of the things we've done recently is what we're calling our "Personalized Patient Center and Care Program," where every person that comes into our institution has care centered around their needs, desires, and frankly, just what they like to do. The Chief Nursing Officer and I created this. After we came up with the concept we thought, "What are we going to do now?" My comment to the Chief Nursing Officer was "let's not do this ourselves, let's give this to somebody that can make it really work." It has absolutely

revolutionized the way we deliver care, and also the patient's perception of care. Our nurses are friendlier because patients are getting personalized care, and they are the same nurses. Our rooms are cleaner, and it's the same housekeepers. But their perception of care has changed dramatically because the patient is now at the center of the care instead of the providers.

Donna Herrin: As we look at the role of the nurse in the future, and it applies to other disciplines as well, we know, as Bob raised earlier, always remembering things is not possible. The evidence is changing so rapidly that the key competence comes with access, synthesizing information, and coordinating and collaborating across the team to the ultimate end of helping the patients and families manage their journey. The work of leadership is to have that patient focus in the middle, equip the teams with the tools to give them the decision support and the decision making they need, and develop systems that keep errors from occurring.

Lynn Dragisic: Adding on to the trust culture, I call it the "safety culture." We are building that in our organization. We believe if you don't have a foundation of trust where managers trust employees and employees trust management, you will not have good reporting, which of course will not result in improvements. What are the things that HR can do to help support that? One is connecting everything to that culture, because that is the only way you can really change it. It's not just a survey once a year. When we do our employee commitment survey now, and we deliver the results to all employees, we connect it to a safety culture. We do a cultural survey to figure out if we have made any progress. We run pilots to focus in on areas where perhaps there isn't a high level of trust. I think there is much that HR can do to support that.

Bob Morrison: As we come back to cost and efficiency, which prompted this discussion, I want to get on the table that when we talk about errors and patient safety issues, waste in health care is where the goldmine is. We have to reduce the number of times errors happen. Our hospital was one of the first in the Medicare Premier Pay-for-Performance Demonstration Project, and we had really good data for the first time. We looked at our pneumonia care, and we were about average, maybe a little better than national norms. The results data came out about a year later, and we were one of the top three hospitals in the country in that demonstration project for pneumonia outcomes. Our cost went down by about 20 percent because patients were getting what they needed at the time they needed it, the length of stay was shorter, and everything went better. Now, sustaining that is tough, but there is a huge amount of money available to us if we can eliminate errors and get things right for patients the first time.

Bob Morrison and Dan Zuhlke

Jean Chenoweth: Leadership has to do with how the agenda's set across the whole organization. We can see in data the impact of the focus of leadership and collaboration, even across various regions of the country. The Midwest, where many collaboratives were set up to work with IHI, is the highest performing region in the country. They have even shorter lengths of stay in the Midwest than in California, which hasn't happened in decades. What that's about is that we are measuring at the organizational level. So what is HR's role in this? How do you measure your impact in terms of how you staff with the skills, with patient centeredness on some units and not on others? That certainly isn't uniform across the country. All of that can be measured. And how do you ensure, once you make improvements in quality, that the staffing changes? One of the things that's true is that if you reduce the lengths of stay, if you don't shift the staff to other revenue generating activities, or increase your patient population to maintain your volume and keep those beds filled, then you have to reduce your staff. I haven't seen HR people stand up very effectively to that. I'm not sure they have been a critical part of making those determinations.

Jill Fuller: I think HR can be. In our organization we run a productivity report with every payroll, which is administered by the HR department. It's a critical part of what we do, and they are looking at it and making sure we stick to that productivity management system we have in place.

I want to go back to HR's role in efficiency in a very concrete example. We are very efficiency-oriented in our organization, and we have a rule that no department can create work for another department. We have to watch that rule with our support departments, and view HR as a support department, just like the C-suite is a support department. I'm overhead; I don't do direct patient care. I'm not part of the product. IT is a support department; infection control is a support department; and if any department creates work for another department, we call them on that. It helps with collaboration, and it helps with teamwork.

Jeff Payne: I was reflecting back, Jill, about how you moved away from annual employee evaluations. As another viewpoint, we have an annual evaluation system that I think is state-of-the-art. It's a multi-faceted process, not an annual sit down review. There are opportunities for managers to sit down face-to-face with the staff; there is self-evaluation and peer evaluation. And of course, we have awards. But the key

thing is that it was designed by the directors as a collaborative team, not by HR. They came together and said "What would make the best sense in our organization?" Because of that the buy-in is enormous. The managers, even though it's an intensive process, generally think it is very valuable, and we feel very strongly it has helped with our engagement scores, which are very high.

I also want to mention something else as we consider our contributions and ways we can align things. One of the things HR deals daily and intimately with is compensation. The challenge is, can we think about pay differently? Can we start thinking incentive pay? Can we start paying commissions to our patient financial services? Can we break things apart? You talk about shock value. Well, we just don't do that, but maybe we should start thinking about that.

Jeanene Martin: I'm interested to hear if anyone is doing anything along those lines. How are you incentivizing employees to move down this efficiency improvement path with you? Are there rewards at the end of the journey, the end of the year, or the end of a project?

Jill Fuller: I believe people are intrinsically motivated, and if you put in pay-for-performance, it's costly to you as an organization. I can't afford to do that, don't want to do it, and don't want people to have the mentality that they need a "carrot" in order to perform. But you can engage employees, if that's what you're asking. They know where the waste is. Front line people know where the waste is. I don't. You need to talk to the front line and say "Where is the waste, and what can we do to make your job better? Let's fix it." That's how you engage in it; it's more important than pay.

Molly Seals: I definitely agree that you want your teams to be intrinsically motivated. I think the unfortunate reality is that where we ultimately want to be and where we stand today are probably in two different places, and part of our challenge is moving people along that journey. As we've done that, we've gone to intrinsic, incentive rewards and gainsharing rewards. We recognize that in an organization, if at any point we are thinking about doing incentives for anyone, then it ought to be somehow tied throughout the whole organization so that everybody is aligned and feeling that same level of alignment throughout. We do that in a couple of different ways. One is with a gainsharing program that ties into the overall effectiveness of the organization. There are basic triggers that must always be met, in order, before even getting into the gainsharing component. Community benefit is a key component of it. We must meet our community benefit targets for there to be any gainsharing paid out. Once you meet the triggers are met, then we get into the actual components of payout, which include a couple of key areas. It includes how we perform organizationally from a net income perspective. Why? Because every single employee impacts that. We look at the 13 key bundles from the Institute for Healthcare Improvement (IHI), how well we do on those particular bundles, and whether we are meeting our quality targets. Those have to be met. You may think that those things are complex for the day-to-day staff to get, but they get it. Patient satisfaction is a piece of it, and we have begun those journeys as well.

Bob Morrison: I want to urge us to exercise some caution and do some homework before we jump too far into incentive compensation. I have seen this pendulum swing a few times. The most widely published article in the entire history of the Harvard Business Review is Frederick Hertzberg's article about how you motivate people. Motivation does come from within the work itself, from advancement and recognition. In our type of team environment, I think some good research and work as to what the highest performing organizations are doing might be helpful.

Molly Seals: This topic was also a very rigorous conversation among our governing board and our executive team. From the governance perspective, it was about a sense of justice. If you are going to talk about CEO incentive, if you are going to provide leadership and team incentive, then there ought to be that same kind of recognition all the way through the organization. Creating the kind of culture that recognizes it all the way through, everybody contributes and adds to what needs to happen. I think this is an area where we don't have enough research.

Talking about the whole area of operational effectiveness and efficiency, and the role of HR - we've talked a lot about patching and layering, putting things on top of things and creating additional initiatives that tend to add costs, compared to taking costs out. One of the greatest opportunities I see for HR is to bring a "blank-slate" to the table., and say "Okay, before we jump into that new system, into that new idea, let's look at it as if we have a blank slate." There are opportunities there on so many different levels. We need to make sure that we're asking and collecting the voices of the customer, and understanding what the challenges are. We need to understand the

ideal outcomes we are trying to achieve. I think the blank slate approach is something HR can bring to the table in a very holistic way. It starts with engagement and involvement, and ensuring that HR is at the table, being part of the dialogue.

Jean Chenoweth: Molly, you couldn't really say anything more important for HR to insist on that, because as the funding for transformation of the industry and the implementation of IT comes to everyone's plate, if you don't start with this blank slate and codify in your IT systems, all of your old systems will result in billions of wasted dollars. That alone would be an enormous contribution that would change the role of HR people in the hospital, because it is very measurable. I can identify many organizations that have wasted billions just because of a failure to do that.

Lisa Schilling: Being from an organization that just spent quite a bit of money on an IT system, we've learned a lot. I think you've made a couple of key points that I think all HR executives need to be mindful of. One is that an electronic medical record is not going to solve all problems. It actually is going to initially introduce more problems. There have been studies that when we introduce the EMR, we will increase the time a physician spends on writing orders and doing the basic things they spend almost no time doing now. How do we compensate for that? How do we have the long view on that and tell them that they are going to spend more time now, but less time in the end?

And just because the IT system's in place, or the EMR system is in place, doesn't mean you are done. What we found is that we have to redesign the processes - we call it optimization - so that they become more reliable than they were before. We did design on the old processes and tried to optimize the process, drop in the EMR, and now we are doing more optimization afterwards and then studying and deciding what kind of information we now need to get out of this IT or EMR system that will tell us whether or not our system's working. It's now no longer just the outcomes and the documentation, but also what the key measures of the process are that will tell us if our staff is doing the right things right. We're a couple of years into this, and it will take us years to find that. HR has to help us be capable of understanding and doing that.

Jean Chenoweth: What role did HR play in facilitating that?

Lisa Schilling: The HR skill, first of all, is onboarding all of the people it took to implement the system. We had to balloon the staffing to get that implemented. And we needed to understand what kind of skills we needed afterwards to help these systems optimize. A lot of that was around performance improvement. One is knowing the technology and how it is imbedded, but the whole implementation plan has to be laid out. Afterward, we need to know improvement and optimization, so we brought people in, and still have people today. We then need to transition that knowledge to the staff. What skills do the staff need to retain, so that they can be mindful as they are doing their daily work? We hired a lot of people with the right skills. I think that is what HR's job initially was, and now it's embedding it in our day-to-day work.

Dan Zuhlke: Molly talked a little bit about the "blank-slate" concept. I think what we are facing today is a situation where things are not going to stop for us to retrench. What we are trying to do is manage this as we're moving along. Another skill I think HR executives really need to hone is the ability to look for organizational capacity. As everybody is trying to do this retrenching and redesign, one of the roles that we play is to step back and say "Do we have the capacity to do all of this work? How does it fit together, and how should we prioritize this so that we can actually make it happen?"

Marty Fattig: One thing I believe is critically important for HR is not necessarily finding the answers, but to be there to ask the right questions so that they get addressed. I think HR is in an extremely good position to do that.


Marty Fattig

Jeff Payne: I can give an example of the IT challenge, and how HR and IT together led the way. The issue was telecommuting. Our IT department was growing so quickly that we ran out of space. Literally, we had two people assigned to a cubicle. As a solution, we needed to have people work from home. HR partnered with IT to develop a template for how that could be done, piloted by the IS department, that the rest of the organization can now use. It was adopted in medical records, and many of those folks now work from home. But there were legal questions, technology questions, questions of appropriateness, and deciding who is best suited to work from home. We had to help marshal in and create the policy to address all of those issues.

Randy Fuller: I think another value that the HR executive can bring is a sense of engagement with and among the employees, because that is going to be critical when you don't know exactly where you are going with this course of reform. How can you lay out a precise course? People are going to have to be incredibly nimble throughout this whole process. If we don't keep them engaged and involved in processes, talking up the channels, and listening to one another, then

we're going to have a real problem. I think keeping folks engaged is going to be increasingly critical.

Bob Morrison: We've been doing employee surveys for years, and we examine the findings and try to make changes where they're warranted. We started doing some "town hall" meetings, listening and

having dialogue with people, asking things like "What are the things that are on your minds as we face economic difficulties? What could we quit doing? What could we do better? What ideas do you have?" As a result, there was an outpouring, and some of it was hard to listen to, because it often included "We have this stupid way we do things," or "We can't find this piece of equipment," and "We have three people waiting while two people scour the hospital for it." When you start to listen to why people leave organizations, it's about bad processes and poor supervision. That's where a lot of the waste is, but our solutions have been about other things. Some of the answers are right inside our organizations.

I looked at our physician survey, and was trying to do some of the same things with physicians. One of the things they said that was frustrating to them, and it should be, is when they write an order they find out a day or two later that because others didn't read the notes in detail, it wasn't done. So I asked, "How often does that happen?" We don't know. What percentage of physician orders that are written get carried out when they are supposed to be carried out? We don't know. I asked a few other hospitals, and they don't know either. If this is how we design care, if the doctor or the architect who writes the plan for other people to carry out, and we don't know whether we carried it out right, there might be an improvement opportunity there. Some of our answers are there if we will just listen.

Jean Chenoweth: I'll share with you a wonderful example of a hospital in California that wanted to change the culture. They began an annual quality fair. They booked the convention center, and each employee had their own posters and a little table to explain how they contributed. It didn't have to do with their incentive pay. It had to do with codifying that all people impact the journey to higher quality.

Much of that was a change in process, but it empowered the people to do something about it. I don't know anybody that can do that except for HR. HR has a very key role to play in developing the culture.

Molly Seals: In our organization we have what's called an "Annual Quality Olympics." What you described sounds very similar to that. A group of employees pick some of the best, most impactful employees, and then annually we have a big awards ceremony. Doctors, nurses, environmental staff, and anyone else who has made a major improvement initiative and affected quality can present to the organization. I think the role for HR is much broader than just planning it. I think it is raising the right questions.

What's the right way for us to put these things in front of our organization, so they serve as the role model for other staff, employees, members of our organization, physicians and so forth? How do we make sure that they recognize that additional effort and role that they've played as one that is valued in the organization and given great priority? How do we help connect the dots to say that this is important? Just through the event, how it's treated, and how people are honored and respected for the great work they do helps connect the dots to say to people that this is really a great thing to do.

HR doesn't plan the event by itself. We have gotten the energy, momentum, and the buy-in from others to recognize the priority. Everyone comes to the table to help pull this event together and help it take place across the organization. It is very powerful. We have now had our fifth Annual Olympics, and it's become a very highly regarded, respected event that keeps sending the message about how important it really is.

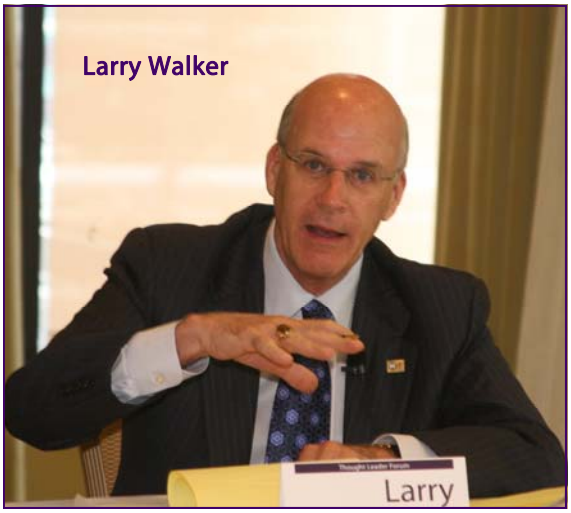
Jean Chenoweth: Have you had a measurable improvement in your processes and quality?

Molly Seals: We definitely have had an increase in the number of people that have been involved and engaged in wanting to showcase their accomplishments. We've seen improvement in the level of engagement and improvement in the bottom line effect of efficiency, measured by net income. That's the ultimate way you know the balance of your revenue and expenses.

Randy Fuller: The question I have is about whether there is a cultural effect or not. You can do these things as an event, like a town hall meeting or some sort of event, but I really think that people are going to have to get comfortable talking to one another everyday. With the types of changes that are likely to come down the pike with payment reform and health care reform, we are going to see things like medical homes that will change the demand patterns in hospitals. They are not going to be written in the federal register, or happen on a specific date. Things are going to start happening for no apparent reason, and your

organizations are going to have to be aware of them. People are going to have to be watching for it and be willing to talk to you about it. So your revenue side people might notice it, or people making appointments who do not hear from a certain physician's office in a long period of time. Those are valuable pieces of intelligence that should be fed up the line. If they are not comfortable talking to you about it, they are just going to sit on it, and you are not going to know. Cultural change is incredibly important.

Lisa Schilling: The real incentive we should be talking about is about being a learning organization. We have what we call "Microsystems." The teams doing the work every day have certain behaviors that they engage in that none of us, top down, could make happen. What we do, and what I think HR's role is, is to incentivize, driving right down to the front line. We don't own improvement. I work in quality, but quality doesn't own improvement. HR doesn't own improvement. Operations and front line staff own improvement. What we try to do is measure and watch how those front line staff improve, know that they're improving, report their improvements, and then learn and share. We're starting to say, "What are the skills of a leader?" Well, the skill of a leader is moving from one unit to multiple units and spreading innovations and practices. We're starting to think differently about incentives and behaviors, and who owns improvement.



Donna Herrin: If I could summarize the role of HR into one word, I would say it's "integrator." It's an integrator with the rest of the C-suite partners. It's having total connectedness at that level to lead the organization. It's being a true partner with the Chief Nurse Executive, the Chief of Medical Staff, the Chief of IT, and whoever else comprises the C-suite in an organization. It's being joined together as part of a senior leadership group that can set the stage for all these things to happen.

Another point I want to make has to do with empowerment and setting the stage. An example is the Transforming Care at the Bedside (TCAB) initiative that came out of the Institute for Healthcare Improvement (IHI) early-on. AONE is very engaged in TCAB, along with learning organizations across the country. Sixty-seven hospitals have just completed their round of TCAB, which empowers the front line staff to make changes at the point of care. I have seen some phenomenal results, and I know Jill will speak to that since she is leading one of those organizations. We're now about to embark on a more widespread distribution of the concept. Certainly, our HR colleagues and our organizations together should all be part of that as we begin to transform organizations right at the point of care.

Jeff Payne: I like the word "integrator," and I totally agree on that as a role. Another aspect of that is management of talent. Getting the right people is much more than recruiting. Once you have the right people, the ones who are best positioned to move the organization forward, talent management is everybody's role. And at our organization our CEO is very much engaged in it. He gets our Leadership Institute. He understands the criticality of developing our front line nurse managers and our front line managers. And frankly, you have to do what makes sense for your organization. Our CEO meets with managers, he has a manager luncheon where he invites managers and sits with them, asking questions like "What's important to you right now? How can we help you to do your job better? How are we standing in your way?"

Jill Fuller: We learned in the Transforming Care at the Bedside project that it's that front-line. When you talk about efficiency, one of the measures in our organization is whether we are decreasing overhead. Are we decreasing the resources we are spending in overhead positions? You can actually look at overhead as a percentage of net revenue on your tax returns. When we started to do this work, 13 percent of our net revenue was spent on our overhead. I believe it's now 7 percent. We can all start to benchmark each other because if you're increasing overhead, you're not becoming more efficient.

Jeff Payne: We're a TCAB hospital as well. We have an initiative going, and we take full ownership. We are responsible for the quality initiatives at the staff level, and that's how it should be. We help them as the results come out. We're just one year into it, so we're just starting to analyze the results, what changes need to be made, and what HR can do to help with the staffing mix, the skill mix and all that.

Walker: ***There is a general conclusion that seems to be emerging, that the people on the front lines know where the waste is. I'd like to see if we can't get a little bit more specific in identifying, based on your experience, where the greatest degree of waste is, and try to quantify that. Jill, you just talked about overhead, and how you can measure it. In your experience, whether you have resolved them or not, what are some other areas where you see waste and inefficiency that, with the right leadership from HR, could make a substantial quality and efficiency improvement?***

Jill Fuller: Time spent in documentation is number one. That's what clinical people would tell you is wasteful. I don't know where HR comes in with process redesign, but I think that someone mentioned that when you go electronic, it can be "garbage in, garbage out." You have to really blow up the medical record and define what the essential elements are.

Walker: ***Some of that documentation would be required by regulation, which you would have to do.***

Jill Fuller: But the regulatory environment should not be an excuse for a dysfunctional system. And practice needs to start informing the regulatory environment. We push on that every day in our organization. Let's get the regulatory system to change. I think we have to find those partnerships.

The regulatory officials need to realize that we have moved into an electronic information environment, and so there is a whole different way we can do things more efficiently, in real time, without our usual tools. We're in a fast paced environment, and we use information very dynamically. We can plan care, and we have teams that do it. We had to make the case with our regulators on how to eliminate the care plan and still have a good product. It took a lot of time to do. We have to work to make changes in some of the traditional ways of doing things.

Lynn Dragisic: In our organization, I think a little different than a hospital, we have watched our robust process improvement within the past 12 months, and trained 40 in-house "change agents." HR has played a significant role in the change agent process. I've heard a lot about change today and about what HR should do, but I think sometimes HR also needs certain tools they can apply systematically before starting a system implementation. For example, how do you develop a shared need up front? How do you make sure that all of the stakeholders are involved? What do you look at? Those are the roles HR has played as a change agent, but with some very specific tools.

Because HR in our organization is very small, we have trained change agents across the organization to get everybody involved. We currently have over 20 projects operating. We completed five projects that reduced $100,000 in travel expenses, which was really significant for us. We found ways to reduce carrying costs of our inventory, which we have in our publications area. We are focusing in on our survey process and identifying efficiencies that we can pass on to the customer. I think that that has been very, very helpful for us, and I think the way we have changed that culture is by involving everyone. We always have it in front of people. Our process is called "Robust Process Improvement." The key is to keep it in front of people all the time. HR is needed and valued at the leadership table, and plays a significant role in that.

Lisa Schilling: One way to define waste is trying the same thing and expecting different results. Some of the waste that we're seeing is in work-arounds. We do the same thing that many of you do. We have 300 people trained in our system to do robust improvement. We train all of our front line in something we call the "Rapid Improvement Methodology." We know that the most significant amount of waste is those work-arounds, so we have to fix those problems. But what other ways do we have? Staffing turnover is another. Another couple of pieces that we see are the throughput issues, such as patients coming in and not receiving the most effective care at every point in the system. We focus on everything, from the time someone enrolls and gets to the first clinic visit, until they return home from our care system. How do we reduce those wait times? Patient waiting is waste. Also, I think my favorite waste is training and policy rewriting.

Jill Fuller: I think that the policy manual is one of the biggest forms of waste in the American hospital, and it should be thrown out. We have an OR policy manual that has three policies. Why should I rewrite a sponge and needle count policy when AORN publishes one that is second to none? But we do that because we have this rule-oriented culture, and it's the way we have always done things. We had a big bonfire and burned a bunch of policy manuals because they were just dumb.

Donna Herrin: I think some of the things we see today in the current environment could look like short-term inefficiency. If we're not careful, it could be long-term wastefulness in terms of having to recreate systems that are now being taken down in some organizations that are not directly related to volume and staffing, but at the direct point of care where resources need to be redistributed during short periods of time. After the crisis settles we have to rebuild systems. I think as an industry we have to be very careful of completely stripping out training funds and severing relationships with academic partners. I don't think it will ever be like it used to be, but we are in a new era. At the same time, we know that we have tremendous workforce challenges ahead. Even though nurses and other professionals and new graduates today in some communities can't find employment, if we sever important relationships, when we do have some turnover the challenges are going to be right back in front of us. I think we need to be very careful about short-term efficiency and long-term waste, because we will get back into rebuilding systems at some point.

Jean Chenoweth: How do you deal with an organization once it reaches high performance? What is your role in preventing it from slowing down?

Dan Zuhlke: I don't know if anyone is performing all that well right now. As a group, our leaders talk about that quite a bit. We think that we're doing pretty well financially, and with our cost and quality. However, people tend to get complacent. Our challenge is to continue to try and raise the bar to the next level by having the right metrics and making sure that they are always in front of people.

Walker: ***What would be examples of some of those metrics?***

Dan Zuhlke: Quality is one. I've never worked for an organization that focused on quality as much as Intermountain. We never have a meeting that doesn't begin by talking about quality. If we don't get to the financial piece of it, we just don't get to it. We try to keep quality indicators in front of all of our employees.

When we do our employee survey, we don't just talk about the results of the survey. We link the data and implications to show how it affects quality outcomes. It's harder in some areas than in others, but we try to use the data so it tells our story all the time. To me, the role of the HR professional is to make sure we are always telling the story with different audiences, but in a way that is meaningful for them. I think that is a big challenge for all organizations, because you always have to execute on a new set of expectations. We should be explaining this to our employees all the time.

Lisa Schilling: Many people may not know that Intermountain has one of the most sophisticated systems for information gathering around quality. I think that one of your key successes is knowing how well you're doing in quality. How has that helped you as an organization?

Dan Zuhlke: When you have the data and you are going to talk about quality, and you want people to behave in a different way, you'd better be able to give them results so that they can see what behavior led to a different result. I think that's key. I think a real critical piece is the physician involvement. Intermountain started out by doing the hard stuff, and that was to integrate the physicians and focus on quality. Once you get that going, the other stuff really becomes easier. It creates a culture where everybody knows that quality is the focus. That's what we do. The other stuff is important, but it's only important if it helps us move what we think our core business is. Continuing to challenge employees, physicians, and all of our leaders, making sure they have the data and always connecting the dots for people, so that regardless of where they work in an organization, they know how their work impacts what we think is most important. It sounds simple, but it is complicated.

Marty Fattig: You have to be really careful who you are benchmarking against. Once you start being successful, four or five years into this, people come to a meeting and say, "When does this get easier?" And I say, "I have news for you: it gets harder. It's like pushing a rock up a mountain. The higher you go the tougher it gets." But once people are prepared and know that, then I think they'll accept it. Second, if you benchmark against the best, many times, that's you. If it is you, then you set your expectations higher and higher, year by year.

Jill Fuller: We've had a productivity management system that collects data on all of our hours and work activity in place for eight years. And we benchmark against ourselves. We know the hours per patient day for the nursing units, and the hours per procedure in the ER, for example, and when people start to meet their standard, we raise the bar. That's how you benchmark against yourself. Quality is a given. We are not going to compromise quality. But if you are talking straight efficiency, then we have big indicators we look at. Our biggest benchmark is what has happened to our paid hours per adjusted discharge over eight years. That is our ultimate benchmark. We have a relentless attention to measurement, and that's helped us keep it sustained.

Jean Chenoweth: We just completed some research, and if you are using census days as your measurement, it has no relationship at all to quality. Per patient day does, which supports the concept of patient-centered care. We find that hospitals that only benchmark against themselves tend to fall behind. The availability of national measures from CMS and many other organizations such as ours keep you honest when arrogance begins to infect your organization.

Jim Collins has written a wonderful book out about how companies fail and how you can know when you're starting to fail. As we have been able to measure how you move on that lifecycle quadrant toward excellence, we can actually see the slowdowns in the hospital's performance. What they have missed is that there is a change in the role of the physician and the caregivers in understanding that you sometimes reach a point where you have done everything you can clinically. Your job as a leader is to say, "CEO, board, get off your tails. It is time for investment if we are to change mortality."

Jill Fuller: You need to benchmark nationally on quality measures. However, in productivity management and efficiency, I don't know that we have defined those benchmarks in the same standardized way as we have quality measures. In hours per patient day on my med-surg unit and your med-surg unit, how do we measure that? We participate every year in surveys from the Labor Management Institute to give them data on that. Well, do you have a mix of pediatric patients and adult patients? Do you have unit secretaries or not? Do you have an IV team or not? We have work to do to standardize some productivity measurement, and I think it will be a lot easier for us to use the national benchmarks.

Molly Seals: I think productivity is a very specific example, and one that all health care organizations are struggling with. The use of agency and contract nurses is a waste of health care dollars. The use of paid hours in areas where you're not getting desired results is a waste of health care dollars. Utilizing a higher skill where it's not needed is a waste of health care dollars.

We are in such exciting times with this dialogue, because we're sitting on the verge of a major change in how health care is going to be delivered and paid for. We're in the midst of a national debate about how are we going to pay for this great resource, who should get it, how they should get it, and where they should get it.

Should they get it in a primary medical home of some type? Should it be more in the home? Should it be in the hospital? The beauty of it is that in this dialogue, what we're wrestling with is how to best deliver it in an environment of change. That's the most exciting part about it. We need to look at the total cost of care - home care, hospital care, hospice care, palliative care, all of the different components - understand the costs around them and then understand how the decisions we make and the approaches of how we deliver care are impacting them. I think that's when we will be in alignment with where the country is asking us to be.

Lisa Schilling: We worked with the Institute for Healthcare on Improvement to create "big dots" for our organization. One big dot of waste for us was reducing patient mortality in the inpatient settings. What we decided was that there really are three big levers. One lever, of course, was not providing evidence-based care. The second lever was actually harming the patients, or providing ineffective care for the patients where we had prolonged the length of stay or admission. However, the third lever we learned was the importance of the right venue of care. We all know about the *Dartmouth Atlas*. With supply, you'll get the demand. We're beginning to look at palliative care programs and repurposing and retraining staff to do things very differently in very different environments. People will gravitate toward the care where it is most appropriate, and many times it is in their homes.

Bob Morrison: Benchmarking can seem like a waste of time when all we do is benchmark against each other. We all went to the same schools and learned to do things the same way, and that's the American system. We have to benchmark outside. In this meeting, if we had two or three HR leaders from manufacturing participating, they would be providing us with some very different perspectives. They live in environments where it's expected that the cost of production will go down each year. We benchmark against Joint Commission requirements and CMS standards that arise out of our traditions, and yet if you go to England, I think the registered nurse staffing level in inpatient hospitals is something like one registered nurse for 12 to 15 patients, because they have mid-level care givers. They have found different ways of doing things, and they get good results. We are going to have to benchmark against some ways that other people are doing things and say, "Which of these will work here?" We haven't thought about benchmarking against how other people in other industries have achieved some of their gains. If we are going to achieve what is being demanded of us, we'll have some of that transformation. I think it will take a lot of support from HR professionals to pull us through that.

Donna Herrin: I think this is a really important point, not just for our industry to look at other industries, but to look outside of the U.S. at health care globally. I just returned a couple weeks ago from the International Congress on Nursing, where there was a global representation of the profession, and there are so many areas where we think we're leaders, and we really aren't. We need to think about our industry as a global industry. While we have to make improvements at the point of care, at the delivery sites within our organizations, we also have to look outside and stay abreast of what is happening elsewhere in our world, because there is lots to learn there.

Lynn Dragisic: Our subsidiary, Joint Commission International, accredits organizations across the globe, and you can learn a lot from these organizations. We started in developing countries, but now we go into organizations that are growing "medical tourism." I think domestically we will probably look more at what they are doing when they become our competitors.

I also think it has a direct implication to the HR staffing functions. There is a shift going on right now in many countries that are revitalizing and reinventing their health care delivery systems. They intend to recruit nurses globally, which means from the U.S. We will probably have some outmigration in the coming years, which will compound our staffing issues. I'm speaking primarily of nurses, but it also applies to all the disciplines that provide care. There is a lot going on out there that we as an industry need to stay in tune with.

Bob Morrison: We tend to lag what other industries are doing to address issues like motivation, employment or retention. When the issue of compensation was brought up, there was a sense around this table that intrinsically people should value the job and should want to do it, so maybe pay may not be as important as we think it is. But think about other industries and the types of gainsharing they have. I'm suggesting that perhaps everything needs to be on the table. I would also suggest that a lot of people are coming into the industry now because this is a viable, solid place to be, and they might not have had the calling to provide health care that perhaps some of us around the table had. They are doing it because it is a great job, and they're perhaps motivated differently.

Walker: ***What advice do you have for your colleagues around the country? What can HR leaders do in their organizations to be a catalyst for the kind of conversation that you've engaged in today? To think about the kinds of solutions that you've talked about today? To muscle their way to a seat at the leadership table? What advice would you give to your colleagues for ways that they can truly make a difference in improving operational efficiency and effectiveness, and dramatically impact quality and customer service at the same time?***

Jill Fuller: I think it is absolutely critical that there is a partnership among the leaders internally and across our professions in the industry as we have these opportunities to talk together. Looking at the models of excellence in terms of how the HR role becomes partnered and integrated into the senior levels of the organization, and sharing that across your organizations is critically important.

Marty Fattig: Many times the issues that the organization needs to address are pretty vivid and well known, and I think it is important that HR communicate to those in the C-suite what value they can bring. I think it behooves everyone to promote their value and contributions; many times I think the people in the C-suite don't realize what valuable comrades their HR colleagues can be.

Donna Herrin: I think it boils down to capability. Now more than ever, the capability of the leaders and the staff to respond to the challenges we're facing is critical. We have to understand how we're onboarding people, how we're training people, and even staffing patterns. HR is critical to this conversation, and leaders that don't understand may not have that solution in hand.

Molly Seals: HR has to be sure they are aligning all systems and structures with what the business wants to achieve. In other words, understanding what the outcomes are and then looking at your reward program, your compensation program, and your performance evaluation system to be sure they mesh well. All too often, there is something in place that is counter to what you want to achieve, and sometimes it comes out of the HR function. That will stimulate the culture we are trying to create.

I would start with being courageous. Be courageous and lift our voice, and really speak up. Be an advocate. I think this area of operational effectiveness and efficiency crosses across every single organizational line, and part of it is making sure that we are an advocate for change and an advocate for the right change and the right place to get the right outcomes.

Another would be to know the people in the organization and the culture. Assess, assess, assess. Understand and make sure you are driving for the change that needs to happen. And last but not least, pay attention to dashboards. Glean information and data, build the dashboards and make sure you understand where you have to change, and when you do change, know how you got there.

Dan Zuhlke: As I think about the last couple of hours of our conversation, and the complexity of the industry that we're in, it strikes me that this was just a snapshot of the things that we have to deal with. As we think about ASHHRA and our responsibility to our members, I think about this complexity and about what our message to our members really needs to be.

We need to be health care executives first, understand this business inside out, and then bring our HR expertise to the table. That really is an important shift in our thinking, and is mandatory if we're going to be

major players in this business. If we don't go in that direction, we are not going to be the type of business partner that our organizations need. We have to be much more than overhead; instead, we have to be counted on as strategic partners at the various levels in our organization who are able to focus on the things we talked about today, which is very critical.

I think about our role as a professional society. At a time when people question the value of pretty much everything they do, the kind of thought leadership that we heard today will help our members.

As Molly said, this is a time for HR people to be courageous, because we don't have all the answers. There is not an HR person alive that has even most of the answers, so it is a time for all of us to be courageous, to think about redefining our role and not letting someone else redefine it for us.

It's a great time for HR professionals. Our industry is at an exciting point, and we need to look at this as an exciting challenge.

Walker: ***We asked you today for a robust, energetic, wide ranging, challenging, and solution-filled conversation, and you certainly didn't disappoint. On behalf of ASHHRA, I want to thank all of you for taking your time to be here with us today, and to share these great ideas for improving organizational efficiency and effectiveness. This is clearly going to be one of the most important things health care organizations will focus on in the coming years, and it will be a critical definer of who the winners are and who the losers are. Hopefully, there will be far more winners than losers if they take much of the advice and ideas to heart that have been shared around this table today.***

Thought Leader Action Ideas

for Maximizing the Role of Health Care Human Resources in Advancing Operational Efficiencies and Organizational Effectiveness

Facilitating a Team-Based Culture Focused on Trust and Patient Safety

- Establish a culture that focuses on quality, making decisions, and evaluating results based on quality outcomes. Link organizational communications and actions back to quality.
- Front-line employees know where the waste is. Increase employee engagement in looking for ways to facilitate a culture of teamwork and trust and minimize waste. This may be achieved through a variety of ways, such as town hall meetings, manager luncheons, or an annual "quality fair" that allows employees to identify how they have contributed to improved quality.
- Understand that the large number of patients and complexity of potential diagnoses is too much for any one person to remember on their own. Move away from the "culture of expert" to one that focuses on processes and teamwork.
- Have a game plan determined in advance for specific scenarios. When a patient arrives that meets a specific criteria or scenario, the entire care team will already know what to do rather than having to stop and determine how the situation should be handled.
- The Chief Executive Officer and Chief Human Resource Officer must be on the same page to encourage the right culture. Part of this includes human resource's role in making it okay to raise issues and potential errors, creating a culture that encourages looking for errors and making change from a system perspective rather than individuals making errors or saving the day after an error is made.
- Create a rule that no department can create work for another department.
- Ensure the individual performance review process emphasizes teamwork. Consider developing a new evaluation process designed by directors and managers to build buy-in and ensure the process meets its intended goals.
- Conduct an annual performance evaluation that evaluates entire teams and pre-defined goals, such as fall rates and errors. Provide rewards for team-based performance and achievements.
- Develop pre-defined performance targets for organizational effectiveness and provide gainsharing payment as a reward. Base gainsharing on the entire organization's performance, because every department and employee plays a key role in overall success.
- Find ways to reward team success that are not financial, remembering that motivation often comes from advancement and recognition.
- Ensure that rewards, compensation, and performance evaluation process are all aligned to encourage the same outcomes.

Ensuring the Right People are Doing the Right Things the Right Way

- Focus on teaching managers how to hire the right people.
- Train managers to be coaches and find ways to allow them to focus on coaching and high-level teamwork rather than bureaucracy and paperwork.
- Before implementing a new idea or system, stop and begin the process with a blank slate. Evaluate the environment, the right individuals to be involved, and what their roles are.
- Some positions may be more efficiently and effectively performed by working from home. Develop a template that the organization can use to determine which positions are most appropriate to work from home, and how to make a successful transition.
- Participate in the Transforming Care At the Bedside (TCAB) initiative that empowers front-line staff to make changes at the point of care.
- Evaluate time spent on paperwork and look for ways to maximize efficiency.

Collaboration and Sharing of Resources

- Create a culture that emphasizes partnerships and integration between leaders in the organization.
- Include the human resources executive as a member of the organization's senior leadership team.

(Continued on next page)

Thought Leader Action Ideas

for Maximizing the Role of Health Care Human Resources in Advancing Operational Efficiencies and Organizational Effectiveness

- Collaborate across organizations through their professional associations, such as ASHHRA, AHA, AONE, HFMA, and others.
- Work together with other organizations to determine the best way to do things, sharing resources and best practices.
- Consider benchmarking systems and processes against other industries, or health systems in other countries.

Leadership Training to Encourage Efficiency and Effectiveness

- Evaluate nurse management positions and determine if they have the right resources and support to perform their complex role in the most effective way.
- Develop an education plan for frontline managers.
- Develop leadership blueprints that identify the training, exposure, and resources emerging leaders should have. This may include classroom learning, online learning, or mentoring. Match current emerging leaders with the blueprints, and fill in the gaps for each individual leader where appropriate.

Measuring Success

- Hold leaders and individual employees accountable for outcomes with the goal of looking for opportunities to improve not punish.
- Build accountability steps into the organization and reward successes.
- Determine the measures that are most appropriate for identifying if work is being carried out in the most efficient and effective ways.
- Measure employee engagement and correlate employee engagement with patient outcomes.
- Set pre-defined success measurements and adhere to them. For example, if a new information technology system is implemented, determine how the system's success will be measured three years later. Then, measure what actually happened and compare the actual outcome to initial projections.

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