

Human Resources Management in the Health Care Business Arena

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Introduction to Health Care Human Resources Management

LEARNING OBJECTIVES

- Identify the components of the unique health care business arena
- Delineate the five critical change factors in the health care business environment
- Understand the basic leadership roles and functions of the emergent health care organization
- Recognize the context for progressive human resources management in a health care organization

H EALTH CARE IN the United States is provided by organizations that are singularly unique in nature and construction, and that have few comparative models across American industry. Many health care organizations are among the best-known institutions in their geographic area, yet they typically operate as nonprofit entities. Although they employ a large number of local citizens, their pay scale and compensation levels are normally

below those of many of the much smaller for-profit organizations in their service community. Very few community hospitals are truly public institutions, yet because they provide emergency care for absolutely everyone coming through their doors, they are widely perceived as public institutions supported largely and directly by federal, state, and local tax revenue.

This chapter explores in a general way the composition of American health care organizations as it relates to human resources management to set a working context for specific organizational development and human resources strategies. Although these organizations can range in size from a small neighborhood or rural clinic to a large metropolitan hospital employing thousands of professionals, there are many instructive similarities, which will be examined first broadly, and then with a specific focus on human resources management. This chapter details the roles and responsibilities of the executive cadre and respective operational ranks of the administrative and patient care sectors of a health care organization, and then describes the causal relationship between a progressive health care organization and its customer-patient community. In addition, this chapter begins to introduce the components of a progressive, successful health care organization by establishing the mainstay foundation—strong human resources management that extends from the human resources office to the executive suite, through the medical ranks onto the patient floors, and across the entire organization. Finally, the chapter concludes with a practical discussion of the critical and significant role that human resources management plays in the daily operations and ongoing success of a progressive health care organization.

DEFINING ELEMENTS OF PROGRESSIVE HEALTH CARE ORGANIZATIONS

Most health care organizations are among the largest employers in their service community and are nonprofit institutions that rely on a very complicated labyrinth of reimbursement funds, charitable contributions, physician fees, and an assortment of other revenue sources to meet their budgetary requirements. Because federal law dictates that no American can be denied health care services from any community medical center's emergency room, for example, health care organizations are perceived to be community bedrocks in the same manner as public schools. Such organizations as the U.S.

Department of Veterans Affairs, which includes nearly 120 large medical centers employing an average of three thousand people as well as nearly four hundred community-based outpatient clinics, are indeed formidable community players, especially in current times.

Many health care organizations also share a laudable history with their respective communities. Urban New Jersey provides three excellent examples of health care organizations that share a wonderful legacy, lore, and legend with their community. In Hoboken, New Jersey, commonly known as the birthplace of Frank Sinatra and the centerpiece of the classic movie *On the Waterfront*, Hoboken University Medical Center (HUMC) has served its diverse community—which features constituencies ranging from Wall Street stockbrokers to newly arrived immigrants living within two miles of the Statue of Liberty—since 1863. In that year, the medical center opened its doors, as did many organizations that were founded during the nineteenth century, as a de facto hospice in which doctors sent severely ill patients to receive terminal care or critical services. Through the years Hoboken University Medical Center, in a city featuring waterfront, education-based, technology-based, and tourist businesses, evolved into both a major community employer and a health care organization that can lay claim to having the most sophisticated technology tracking and assessment system in the state of New Jersey.

Furthermore, HUMC is a community-driven health care organization that seriously embraces the charter of providing its community with stellar “cradle to grave” services—everything from childbirth to pediatric services to emergency care, and across the spectrum of critical and elective surgery care. Health care organizations maintaining this charter are the ones that the majority of experts believe will be most likely to thrive in an era in which American health care constituents are more exacting, demanding, and educated, because they represent the first defining element of a progressive health care organization:

We do everything here.

Newark Beth Israel Medical Center (NBIMC) opened its doors in 1898 in the state’s largest city. By 2009 it had become one of the flagship organizations of Barnabas Health, the second-largest employer of any kind in the state of New Jersey—particularly noteworthy when one considers that New Jersey is the most densely populated state in the United States—with

nearly 24,000 employees, six major medical centers, and over forty clinics and ambulatory care centers. Despite the religious resonance of the system's name (based on its flagship medical center, which coincidentally is also the state's oldest), Barnabas Health is secular and nonprofit, and rates second only to the state of New Jersey itself as major employer, human services provider, and educational center in terms of employee populace. Since its opening as a prototypical general hospital, Newark Beth Israel Medical Center, now 3,585 employees strong, also includes the Children's Hospital of New Jersey and one of the highest-rated cardiology centers in the United States, and is the major provider of virtually every type of health care service needed in the state's largest urban center. As an organization that prides itself on "growing its own and hiring from within the community," it is not uncommon to find employees at NBIMC who are third-generation "Beth employees." Further, one of the current vanguard initiatives of NBIMC is the Start On Success (SOS) Program, which is the epitome of a community employee development program. This program provides selected high school seniors in the City of Newark public school system with an opportunity to complete their education in the morning on the campus at The Beth (as NBIMC is commonly known across the organization and in its service community). In the afternoon the students undertake responsibilities in part-time jobs that provide training in such areas as patient transport, entry-level nursing, security, food services, and other critical vocational areas that are always in demand in a health care organization. With this everyday, resonant charter, proven over a hundred years now, The Beth personifies the second defining element of a progressive health care organization:

Quality care begins with quality people.

Across town, in Belleville, New Jersey, made famous as the home neighborhood of pop icons Frankie Valli and the Four Seasons and Connie Francis, Clara Maass Medical Center (CMMC) has been in business since 1888. Originally named German Hospital because it tended at its inception to the majority community population of recent American immigrants from Germany, CMMC—still with its original, formidable brick facade—became the local provider of choice, establishing a reputation as a training center for medical and nursing personnel. In fact, a cohort of physicians and nurses not only provided research and direct patient care in the areas of general medicine

in the late 1880s but also became pioneers of critical medical research. Specifically, a group of physicians and nurses from German Hospital worked assiduously for a cure of yellow fever. One of the nurses—Clara Maass herself, a young German American nurse from the neighborhood—not only participated in the research but also offered her life in volunteering to be the first human subject for the vaccine that eventually cured the malady of yellow fever. The hospital was rightfully rechristened in her honor and to this day exemplifies the third defining standard of a progressive American health care organization:

What we did yesterday might be good enough for today, but we constantly have to learn anew and face the challenge of being better tomorrow.

Health care organizations such as these three have survived the conundrum of how to provide quality health care by adhering to these principles, which, as we will see, take root in strong health care human resources management.

CURRENT PERCEPTIONS OF HEALTH CARE ORGANIZATIONS

At present many **customer-patients** consider themselves to be educated about health care and, thanks to mass advertising through traditional media sources and on the Internet, often pride themselves on being informed consumers. As already mentioned, many American health care organizations possess a reputation, sometimes good and sometimes not so good, in their community based on history and past performance. However, with the recent spotlighting of health care by politicians and legislators, among other factors to be discussed later in this chapter, health care organizations today endure more scrutiny than ever before.

This scrutiny begins at the physician's office, the time-honored entry point of health care in the United States. Starting with this interaction, the health care consumer believes the *what* of health care—that is, the actual product of health care, augmented and supported by cutting-edge technology and the latest medical devices—is likely to provide a sure cure at the highest possible level of care. However, what is being more closely assessed now than at any other point in health care history is the *how* of health care—that is, the “human touch” that is afforded to customer-patients by all employees,

volunteers, medical professionals, and administrative leaders that they encounter through their healing experience. Because health care customers pay more, and believe that they are better educated than health care consumers of previous generations and are aware of more dimensions of care, the element of health care that we define as the human touch—and that traditionally has been referred to as bedside manner—often supersedes the actual product when patients evaluate care. This reality demands a strong human resources management department that can help maximize the organization's human capital on a daily and progressive basis.

On a related note, a consumer and a customer, as per the traditional thinking in marketing, can be two different people in health care. The consumer, for example, in an equation involving services for the aging, could be an aging parent. The customer—that is, the person making the decision—could be the son-in-law or daughter-in-law of the aging parent, because he or she is most likely to be objective in the decision making and the most demanding, wanting to achieve the highest possible level of satisfaction with the outcome. However, the customer patient's overall perception of the quality of care, which is always founded on the quality of his or her interaction with staff members, is still the primary consideration in the customer-patient's decision making.

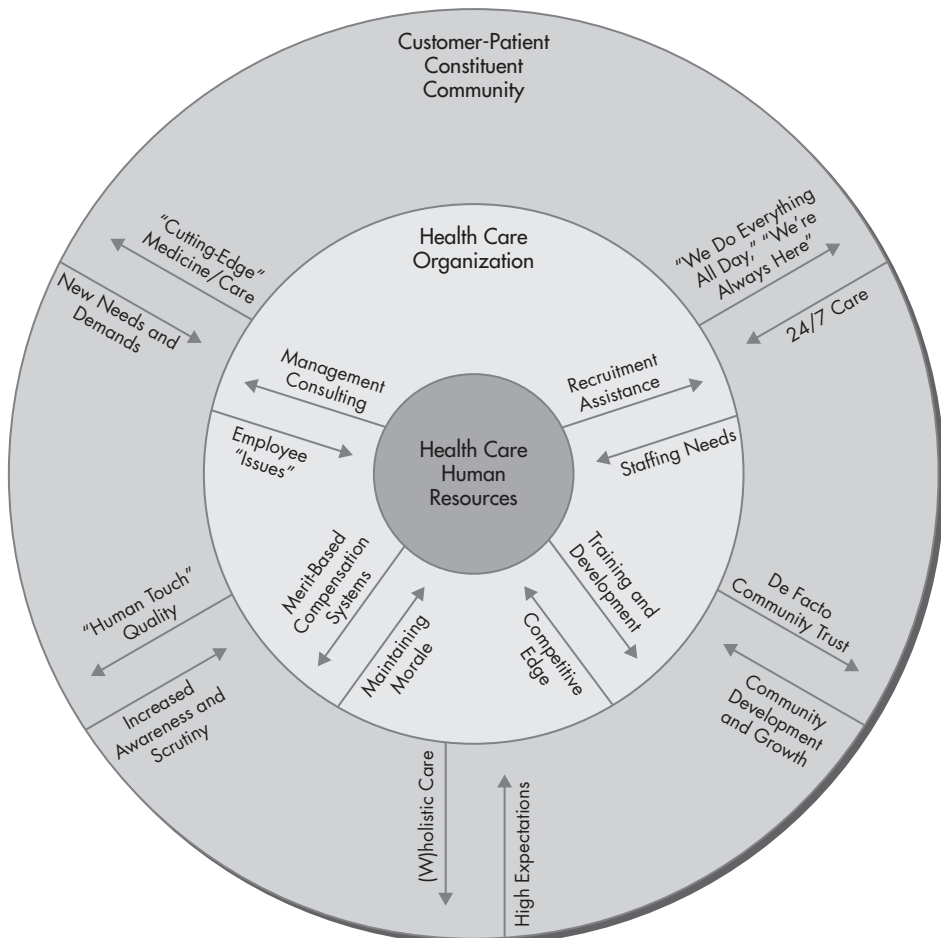
The fact that health care nationally represents one-sixth of the U.S. economy by most government estimates, comprises organizations ranging from physicians' offices with a dozen employees to organizations like the Barnabas Health system that employ tens of thousands of employees, and offers a distinctive "high-demand, essential need" product only complicates the calculus when assessing the unique health care environment. Furthermore, 18 percent of the national workforce works in the traditional delivery of health care, with another 9 percent estimated to work in ancillary organizations that provide products directly to health care organizations, such as food services organizations; uniform distributors; technology management firms; and others that help support these organizations, many of them with massive physical plant facilities. In numerous cities health care organizations are among the largest employers; in fact, in every one of the thirty largest U.S. and Canadian cities, health care organizations represent at least three spots on all lists of the top twenty employers. In the early 1960s any of those lists would have been replete with manufacturing

organizations—service organizations now dominate those lists, and the largest organizations, both in terms of physical plant size and number of employees in the service sector, are part of health care.

SPHERES OF INFLUENCE MODEL

Figure 1.1 demonstrates the **Spheres of Influence Model**, which is a very useful tool in charting the various impact factors that influence the health care organization in general and the human resources management

Figure 1.1 Spheres of Influence Model



department in particular, which is the primary catalyst in a successful health care organization.

As pictured in the diagram, there are three sectors that make up the Spheres of Influence Model of health care. The first sector and the widest impact area is the customer-patient constituent community, which presents an array of risks and challenges on a daily basis to the modern health care organization. The community persistently puts a significant amount of pressure on the organization, based on customer-patient expectations centered on the naturally prominent role that a health care facility plays within its given operating environment. In addition, the ever-demanding customer-patient community's desire for new services and innovations must be sated by the health care organization. Demands for **non-traditional services**, such as preventive medicine and health education, must also be factored in when considering the expanding demands on a health care organization.

The second concentric circle in Figure 1.1 represents the primary recipient of the stress and pressures from the customer-patient community and external competitive environment—the health care organization. However, there are internal demands within every health care organization that also present a cacophony of challenges. To begin with, health care organizations are repeatedly confronted with major fiscal and financial pressures, and most nonprofit health care organizations struggle daily to “come out even” at the end of the given fiscal year. Health care organizations also wrestle with the difficulties involved in having a limited amount of skilled personnel in the face of customer-patients' increasing demands for new services and personal attention. Adding to this conundrum is the consistently high turnover even in well-managed and well-financed health care organizations operating in metropolitan areas in which there is a dearth of health care human capital talent. Turnover of personnel is even more perilous in areas in which consistency of performance can be threatened as staff members go from one organization to another for slightly better financial compensation.

Stress is also evident within a health care organization on the part of employees who live in the community—and approximately 90 percent of health care employees usually reside in their organization's service area—and contend with questions and comments about their employer constantly, even when going to a grocery store or attending a child's school activities. Unlike

their fellow citizens who work at a private corporation or somewhere outside of the community, health care workers are commonly known to their neighbors and friends, and are seen as a source of information and expertise. Finally, the stress caused by nonperformance on the part of nonplayers—an organization's employees who do not meet performance expectations but still manage to stay employed—can greatly affect the daily action of a health care organization and indeed can cause the implosion of significant work objectives.

The innermost sector of the Spheres of Influence Model is the human resources team, representing a nuclear department within a health care organization. As pressure for great performance moves from the customer-patient community through the organization to individual work groups, all members of a given department are challenged with the mantra “We must do more with less.” The reality in health care human resources today is that many staff members are doing “everything with practically nothing” as they seek to meet the demands of the organization. In smaller departments, a turnover situation in which a vacant position is not filled immediately can create additional pressure on the other members of the group to work even harder and dedicate even more time to attending to the business of the department. In all cases, members of the human resources management department must have a strong working knowledge of their department's objectives in relation to the overall mission and vision of the health care organization to fully dedicate their efforts and talents to the accomplishment of organizational objectives.

The role of human resources in a health care organization cannot be understated. Given that human resources professionals are the prime agents, in concert with line managers, in recruiting, training, and developing employees, the charter of health care human resources is indeed challenging and demanding. Every health care employee is potentially the first point of contact for the customer-patient, and can create the all-important initial perception of the health care organization in the eyes of that individual. All health care employees are leaders, and are asked on a daily basis to “lead the action” relative to their technical expertise, which is the essential product of the health care organization. Furthermore, recall that most customer-patients are interested not only in the *what* of a health care organization but also more vitally in the *how*—the manner in which health care is delivered. In fact,

most customer-patients assume that they will get effective health care—what they are assessing is the human touch provided by each employee they encounter. Every employee therefore acts as an exemplar—good, bad, or marginal—of the entire organization’s ethos. Together with their peers, employees collectively form an “organizational personality” that becomes the most formative aspect of the customer-patient’s perception.

Considering the demands starting with the customer-patient and extending to each employee at the nucleus of the spheres of influence, it is important for an organization to constantly strive for a human resources composition that represents a majority of steadies and superstars. The application of a Performance Matrix (see Chapter Three), first in concept and then in daily practice, is vital in maintaining sound customer-patient services as well as in developing the organization to a maximum performance level.

Most people don’t want to pay more taxes or higher bills. Moreover, all people want to have their money’s worth, so as people pay more exponentially for health care services either through insurance premiums, indirect taxes, or a vexing combination of both, it is logical to assume that the customer-patient will be more demanding than ever for “perfect outcomes” in all of their personal experiences with health care. Accordingly, all health care organizations must provide the “latest and greatest” at the lowest cost ratio for the customer-patient; members of the human resources management department must, working with line managers, ensure that they hire individuals who not only demonstrate a mastery of the *what* of health care but also, and perhaps more important, perform at a high level in regard to the *how* of health care, best exemplified in the goal of providing an outstanding human touch in all interactions with all customer-patients.

FIVE SIGNIFICANT CHANGE DYNAMICS OF MODERN HEALTH CARE

The health care business arena is one that is teeming with change dynamics and daily challenges that affect each and every staff member of an organization. The antecedents of many of these changes are actually traditional demands on health care that have intensified over the past ten years due to a number of catalysts. In fact, most health care professionals would agree that

there has been more change than ever over the past ten years of health care and, moreover, that there will be even more pressure and stress related to change forthcoming in the next five years. This section examines the five major change dynamics of health care, all of which have an impact on both the employee profile in all jobs in a health care organization and the organizational role that human resources plays in a health care organization.

The starting point for understanding the intensity of pressure on a health care organization is learning more about customer-patients' prevalent perceptions. In current American society, perception has become more important than reality. As a basic component of human nature, individuals develop strong beliefs, based on subjective observations, that ultimately result in an adopted perception and conviction. For example, if a customer-patient recently has had one negative experience with a member of a nursing staff at a given health care facility, a conviction takes root that the entire facility is bad news. In the perception of that customer-patient, the validation is "Hey, who hired that bad nurse to begin with?"

Subsequently and consequently, with a little negative word of mouth, a community perception could then be easily established that all of the nurses working at that health care facility are not particularly skilled—a perception that becomes more important than any facts or data presented in defense of the nurses' abilities. In this manner, perceptions are formed daily and almost instantaneously in our fast-paced society that demands quick satisfaction, immediately accessible data, and perfect results.

Therefore, it is vital to consider the most important "factual perception"—that customer-patients are perhaps more "customers" than "patients." This is the result of American consumers' understanding that they have a choice when selecting a health care provider. Not only will their insurance company inform them of their various choices and options through enrollment guides, 800-number help lines, and physician network listings, but also the attending physician will often provide an array of choices if they hold privileges at more than one hospital. As another example, such Web sites as WebMD provide information that is presented factually but can in fact be more general than specific. However, customer-patients who believe that all information on the Internet is valid can form an erroneous "factual perception" (which indeed is a perilous oxymoron) before even visiting the doctor's office or a health care facility. At that point it becomes even more problematic

and difficult for caregivers to gain the trust of their constituents, who have become apprehensive and fearful while forearmed with the “latest Internet facts” relative to their condition or malady.

With the terms *customer-patient* and *perceptual reality* in mind, it is time to explore five major impact factors that place ever greater demands both on health care facilities and on each employee trying to deliver sound health care during times of change, chaos, competition, and confusion.

Life-or-Death Outcomes

Customer-patients often believe that almost everything involving a health care facility can result in an outcome with a potentially drastic impact on their health care and quality of life. For example, if a six-year-old child attempting to ride his new two-wheeler bicycle falls on the pavement and opens a gash on his hands while bracing his fall, the parents’ first move will be to rush the child to the emergency room. Try as we might to educate health care consumers on not abusing the emergency room with minor injuries, we must conclude that when the shocked parents of a young child see blood, they are going to make a dash, child in tow, to the nearest trauma center. Assuming that stellar health care is provided—that is, there are no problems with the attendant paperwork or with processing the insurance card, and a physician sutures the wound quickly and effectively—the prevailing question from the parents concerning this somewhat routine episode would be “Wow, my child received stitches! Will he have a scar *for life*?” It is also a fair assumption that the parents might even make an initial inquiry about the availability of plastic surgery at the facility in the future to remedy any scar resulting from the injury.

Another example of the “life-or-death” perception prevalent in the collective mind of American health care customer-patients is in full evidence every time you attend a birthday party. Whether the birthday boy or girl is four years old, fourteen years old, or forty years old, at a certain point during the celebration the parents of the honoree will recount for all of the attendees the adventure of the birthday celebrant’s birth. If you listen carefully, you will hear not only an assortment of details about the *what* of the birth, such as the physiological details of the delivery, but also many of the *how* facets of the delivery, such as in the assistance provided by a security guard, the compassion of a nurse or doctor at a critical juncture, or even the extra effort put forth by

a housekeeper or environmental services worker to make the new mom's room more accommodating for visitors. When the *how* factors are rated well, the perception of the parents and family—especially the mom—will undoubtedly be positive. However, even if the *what* factors are positive, if the *how* factors are negative the entire experience will be judged as negative, and the parents will probably seek another health care facility for their next medical need.

Escalating Expectations

In a general sense, it is somewhat easy to define the prevalent expectation of today's customer-patients. In essence, "they want everything at once without waiting in line with perfect outcomes, while great, skilled, intelligent staff employs the best equipment with the latest innovations in medicine and treatment while obtaining perfect outcomes while treating the customer-patient like royalty and without the customer-patient paying a dime for anything," to directly quote an emergency room nurse at a Philadelphia hospital. It is important to understand why this confounding expectation is evoked at present from coast to coast, regardless of the type of insurance or health care coverage an individual maintains.

To begin with, all of us pay exponentially more for our health care now than we did even a mere decade ago. Insurance costs have skyrocketed, and many large employers have passed the cost down to their employees. Even many major corporations with a reputation for being "best companies to work for," such as Wegman's, and strong state teachers' unions in Wisconsin and New Jersey have received constituent backlash and negative press coverage for asking their employees to incur the cost for a fractional part of their health care coverage. In the 1960s most American workers received full "hospitalization" as part of their employment package; in the early part of the twenty-first century, however, many American workers are becoming all too familiar with such terms as *health maintenance organization*, *physician organization*, and *copayer*, with the last term almost taking the semblance of an obscenity. The American way is to expect more when one pays more for services of any kind. Accordingly, it is at least logical to assume that customer-patients paying more for health care services from their own pockets expect more.

Furthermore, the American health care customer-patient believes that he or she has significant knowledge about health care. In the words of a nursing home director in Washington DC, "They either know more, think that they

know more, or know that they better learn more about their coverage and the type of health care in their area.” As individuals learn more about health care, whether or not their information is correct, they naturally expect more, as Web sites, the media, and even advertising from health care facilities present paragons of health care delivery that the customer-patient then expects as part of the routine delivery of health care. As a result, a pharmaceutical advertised on television, such as Claritin, becomes the “drug of demand,” and the suggestion of a generic substitute is perceived—and remember, perception *is* reality—as an attempt of the caregiver to give the customer-patient second-rate care. As another example, the customer-patient who is familiar with the ubiquitous television commercial featuring open-air MRIs is likely to subsequently be less willing to endure an examination in a closed-air MRI. This type of commercial not only heightens the expectations of the customer-patient but also puts additional pressure and stress on the caregiver, who must break the customer-patient’s adherence to a media-driven misconception of the relative efficacy of contrasting medical equipment and replace it with a truly realistic, effective treatment plan.

Health Care as a Media Target

Along with education, health care is a prominent sociological issue and a favorite target of the media. Because virtually every American has had experience with health care, any story dealing with health care will find resonance with an audience that is increasingly interested in the performance of local health care institutions. The media thus approaches health care from three different vantage points—the journalistic media, the advertising media, and, perhaps the most powerful, the popular media.

Today, in any part of the United States or Canada, there is bound to be a newspaper article about health care in some form, which is usually written from a negative point of view and often relates a “horror story” of negative circumstances. Reflecting the maxim that “bad news always sells,” articles of this genre can be found both in tabloids and in more serious, respected newspapers and on news programs. With the emergence over the past fifteen years of such “twenty-four hours a day” news stations as CNN and MSNBC as well as a multitude of news-laden Web sites across the Internet, there are more news outlets than ever to bombard the sensibilities of the North American customer-patient. Major medical breakthroughs are reported

misleadingly or are presented sensationally, such as through stories of the separation of Siamese twins or the repair of three-armed babies. Health care policy pieces that help inform and shape public opinion can often run alongside these “medical miracle” stories in the printed, broadcast, and Web-based outlets of today’s daily news.

For example, *USA Today* recently displayed on its front page a “scientific survey” sponsored by a leading pharmaceutical company that listed the five most prominent fears of one thousand respondents who were facing surgery. Whereas fear of not recovering from the surgery was the “number one concern,” an apprehension that the patient would be mistreated, misinformed, and mishandled by hospital staff was the “number three concern.” Although it is disconcerting that this ranking was substantiated by the majority of the one thousand survey respondents who hold both fears to be valid, the fact that nearly four million people read *USA Today* on a daily basis and would be influenced negatively by this “scientific survey”—after all, it was on the front page of the paper!—is indeed troubling to any health care staff member attempting to settle the fears of a community member facing surgery.

The advertising media also contributes mightily to the creation of perceptions relative to health care. As mentioned previously, advertisements that feature “groundbreaking” new drugs, new equipment, and breakthrough procedures serve to heighten the expectations of customer-patients and create popular demand for the “newest and latest” medical innovations. According to one senior executive at a Connecticut medical center, “We do disservice to ourselves when we promise miracles.” In every competitive health care market, there is at least one noted health care provider that spends an inordinate amount of money advertising a cutting-edge department, such as oncology; the ability to provide a new procedure, such as sophisticated eye surgery; or an affiliation that provides partner services with a nationally recognized “name” institution, such as Sloan Kettering Cancer Services or the world-renowned Mayo Clinic. Without question, the provision of new, sterling services is great for the community; however, in an unintentional but implicit manner it also creates higher expectations on the part of the customer-patient and the community.

Even investment firms have gotten into the act relative to the advertising media. For example, a major Wall Street financial management firm recently ran a print advertisement in such national magazines as *Time* and *Newsweek*.

The ad featured a patient who obviously just emerged from surgery, as evidenced by bandages around his head and his wearing of a surgical gown, who had to wash dishes to pay off his hospital bill. The caption under the ad read, “How do *you* plan to pay for unexpected medical bills?” Needless to say, such advertisements serve only to create fear, not only of the caregiving process but indeed of the entire business continuum of care from insurance coverage to payment of outstanding bills.

Even when positive health care images are presented in the advertising media, a “backfiring” effect can occur. For instance, if a potential customer-patient sees perfect outcomes, pleasant staff, and immaculate “guest” rooms in advertisements for a health care facility, she will expect absolutely nothing less to be the reality when she checks into that local hospital. If the conditions do not match the ideal situation featured in the ad, the customer-patient is certain to feel that the hospital was disingenuous from the outset. This quandary is similar to that of a hungry consumer who passes a billboard featuring a perfect hamburger from one of the many fast-food providers in his community. When he orders the hamburger featured on the billboard an hour later and it does not match the opulent appearance and tantalizing glow of the billboard version, disappointment and perhaps even anger form a negative consumer perception. In a similar but more important way, the natural inability of a community hospital to match the perfect conditions featured in its resplendent advertisements can also create initial distrust in the customer-patient service cycle.

Finally, the popular media is overflowing with characters and images that do not bode well for positive consumer perceptions of modern health care facilities. Consider the media icons of the 1960s and 1970s television world. Such physician heroes as Ben Casey were able to do three surgeries, set the administrator straight, conduct a very busy personal life, and perform laudable community service—all within an hour, including commercials. Marcus Welby, MD, never even left his house—he would send his young intern, played by a pluperfect James Brolin, off on a motorcycle to gather patients—and then would regularly save the day, week in and week out, through a series of house calls, office visits, and the strength of his august, patriarchal personality.

Today viewers are assaulted with a series of negative images and unsavory characters associated with health care that naturally create negative

perceptions. The doctors on the erstwhile but syndicated hit show *ER* seem to spend more time delving into personal angst than attending to their patients in any purposeful manner. The thankfully canceled psychodrama *Chicago Hope* once aired an episode in which open-heart surgery resulted in the patient's heart's being dropped, kicked, rinsed off in a sink, and then stuck back into the unconscious patient's chest cavity. It would seem that media depictions of health care scenarios do little to assuage the fears and apprehensions already inherent in an always skeptical and often frightened customer-patient populace.

A good insight into the strategy of the popular media in regard to depicting health care was discernable in an interview for this book with an actress who plays a leading role on ABC's premier soap opera, *All My Children*. When discussing the script meetings for planning medical and health care sagas on the show, she said that the first consideration is always "What would be the best opportunity to inject drama into the mix?" Some recent scenarios resulting from these objective-based meetings include doctors blowing operations because they were thinking about their romantic lives and nurses failing to answer trauma calls because they were arguing on their cell phones with their most current paramour. When asked if any consideration was given to the fact that some viewers might think that those representations are "what really goes on in a hospital," our leading lady offered a pointed reminder that "that's not important in planning a *real* dramatic scene in my business."

Public Trust

We live in an era in which more people cast a vote for the best singer on *American Idol* than vote for the leader of the Free World in the U.S. presidential elections. The popularity and credibility of politicians have reached an all-time nadir as stories of corruption, higher taxes, and fiscal mismanagement appear daily throughout all forms of the media. Unfortunately, the delivery of health care is often perceived as a facet of public services. Although it is a fact that a number of municipal hospitals and the entire Department of Veterans Affairs medical system are true public trust entities directly supported by tax dollars, a number of academic surveys indicate that an overwhelming majority of American citizens believe that *all* health care facilities are supported by both property taxes and local sales taxes in the same manner that public schools receive financial support.

Accordingly, a comparison of public schools and local health care facilities is useful to understand how this perception abets the escalation of demands for constant improvement and new innovations in health care facilities. To begin with, when a child is registered at a local public school, the parents are not the least bit concerned about a tuition payment, as they inherently know that tax dollars will support the child's education, and, moreover, they hold close the patriotic belief that access to education is a given right for all American citizens. In a similar vein, any American citizen can receive health care at his or her local emergency room, where payment for services is often not a primary concern of the patient-customer yet is paramount to the hospital's survival. As a matter of law, no one can be refused treatment at an emergency room in any one of the fifty states, as evidenced in a landmark case in New England several years ago in which a civil judgment was made in favor of a patient who was refused treatment in an emergency room. This well-known case stands as a reminder that access to emergency room care is in actuality an unalienable right beyond just perception. From another perspective, when property taxes are raised in the community a common ploy of both politicians and real estate agents is to cite the excellence of both health care and education within the community as the reasons why property tax revenue must be increased. Also, consider how many of our local hospitals include in their nameplate the words *community*, *memorial*, and other appellations that suggest a connotation of public trust.

As a last point concerning this customer-patient perception, many Americans would agree that both health care and education could use vast improvement in many regards. However, the idea of "nationalizing" either entity is an anathema to any taxpayer who has worked hard to make a good income so that he or she can live in a community with solid schools and sound health care. In neither case will the taxpayer be willing to accept "nationalization leading to marginalization." This latter perception reflects the old adage of the late U.S. congressional leader Thomas (Tip) O'Neill that "all politics are local," and individuals are more interested in circumstances within their local community than in the entire national realm of health care and education. Accordingly, it is apparent that any nationally driven legislation attempting to "fix the broken American health care system" will meet popular resistance. In addition, a national opinion that health care and education are well funded but often lackluster in regard to quality will continue to have a deleterious impact on customer-patients' perceptions well into the future.

“People Intensity”

The number of people who work in health care facilities is also worth noting. In the 1960s the American economy was based on a reliance on manufacturing entities; now, with many manufacturing jobs exported overseas and with a centric focus on service industries, health care has emerged as a leading employer in every American community, as already discussed. Health care organizations are therefore perceived not only as agents of the delivery of services related to life and death but also as the “major employers in town,” receiving increasing scrutiny across the country for their organizational ethics, hiring patterns, and competitive status relative to other organizations.

Also, the biggest daily challenge confronting health care leaders at every level—and an ongoing subject throughout this book—is maximizing the performance of their staff. However, the amount of time that a health care facility will spend interviewing and selecting a computer or information technology specialist, for example, is miniscule compared to the amount of time that the facility will spend in selecting the type of computer system. The problem here is that if a computer fails, a service contract includes a warranty to ensure its performance; if the computer specialist fails to meet organizational expectations, the organization will have to expend a significant amount of time, energy, and money in attempting to redirect performance and, often, subsequently terminating and replacing this unsatisfactory employee.

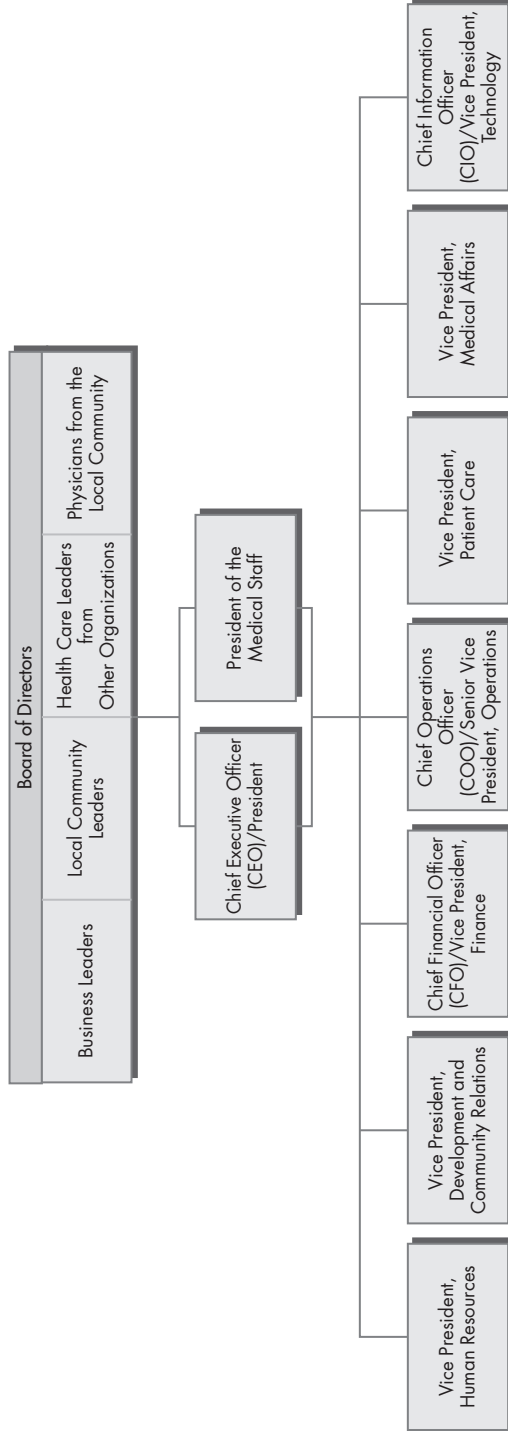
It is difficult to imagine that the impact on health care of any of these five significant change dynamics will lessen in the near future. It is therefore an imperative of every health care leader to select, develop, and retain stellar employees who will meet the ever-escalating expectations resulting from these five prevailing dynamics.

PROFILE OF A PROGRESSIVE HEALTH CARE ORGANIZATION

Given all of these realities, a successful health care organization must be structured to maintain timely response capabilities proactive planning, and sustained growth to meet the needs of a demanding constituency of customer-patients.

Figure 1.2 illustrates the functional composition of a progressive health care organization. Consider as an example the most common form of health care organization, which is a local, community-driven medical center. This

Figure 1.2 Organizational Chart — Midsize Community Hospital



representation not only is typical of the organizational dynamics at the majority of health care organizations but also contains components that can easily be extracted, reduced, or expanded to represent all health care organizations. This example will also provide a construct for an efficacious health care human resources component, which will be examined in detail later on in this chapter and indeed throughout the entire text.

The governance structure of a typical community-driven health care organization begins with the board of directors. Most health care organizations have a board of directors consisting of ten to twenty-five members drawn from the community, including business experts, local legislative and political leaders, medical and health care experts from other organizations, and educators and social leaders. The role of the board is to provide governance and guidance on such significant issues as growth and development plans, strategic direction, and relations with local and state governments. Most successful health care boards of directors have at least a committee or subcommittee that provides counsel on education, human resources, and organizational development issues.

The titular leader of a health care organization is typically the chief executive officer (CEO), or the president. As is the case in most industries, the CEO is the key decision maker who has the vision of the organization, the trust of the community, and the growth of the health care enterprise as his or her functional charter. At most health care organizations the CEO has ascended to the executive suite after an impressive career in either administrative management or medical leadership (usually the former). Although the CEO might only have seven to twelve direct reports, every member of the organization is in the CEO's chain of command. In any successful health care organization the CEO will take a fervent interest in human resources and be an active and appropriate participant in key recruiting decisions, training and education initiatives, and other high-priority human resources endeavors. The CEO's importance in the organization cannot be understated, as many health care organizations that have enjoyed the benefits of favorable demographics and potential high revenue have failed because of poor leadership at the top and decision making that was less than responsive to the emerging needs of their constituent community.

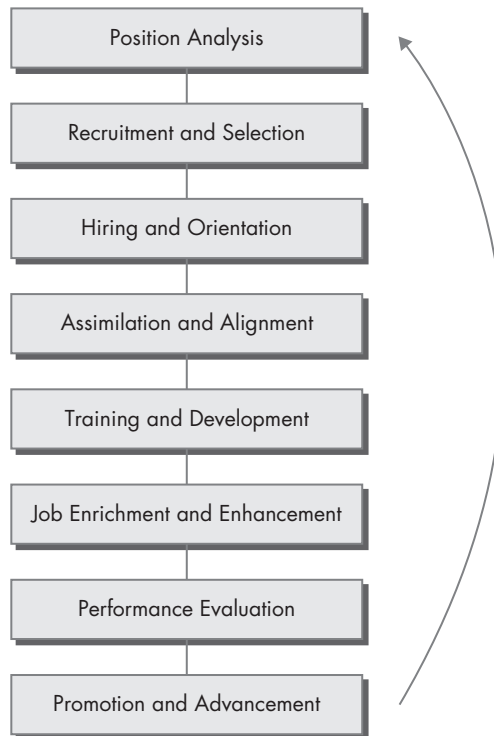
The next layer, as indicated in Figure 1.2, is commonly called the second tier of health care leadership. Most health care organizations have a chief

operating officer (COO) who is often the second-in-command of the organization and is in charge of all of the physical plant operations, support operations, and other major facets of the health care organization. This individual usually has a set of directors, such as a chief of security, a director of food services, a manager of plant engineering, and other professionals who lead skilled staff in the daily operations of the health care organization. **Technical training** (often called in-service education in health care) is very important in health care operations, and that becomes a joint endeavor with the human resources management department in successful health care organizations in which a variety of perspectives are synergized into smart decisions. Naturally, recruiting for skilled positions is also a major concern for the COO, or the senior vice president of operations, as is the identification of competitive salaries, wages, and benefits needed to attract the highest possible level of professionals in the health care arena.

Another key leader in the second tier of a health care organization is the vice president of patient care, who normally is the executive leader for the largest employee population, as patient services encompasses nursing and other direct patient care departments. Because shortages abound in many patient care specialty areas, including nursing, pharmacy, physical therapy, dietary services, and other direct patient care sectors, the entire chronology of employee acquisition and development, as detailed in Figure 1.3, becomes critically important to the vice president of patient services. Often this individual has ascended to his or her position through a nursing career pathway and thus understands intrinsically that although many customer-patients might not remember the name of their operation or the specifics of their aftercare, they will *always* remember the name of the nurse and the other direct patient care providers who assisted them in a time of need. Therefore, by working in concert with the human resources management department, the strong nursing corps and augmenting team of diagnostic and therapeutic professionals that make up the patient services corps can become the flagship human capital component in a progressive health care organization.

An oft-recited mantra in health care is “No margin, no margin mission,” alluding to the fact that financial revenue must be healthy if the health care organization is going to succeed in making its community healthy. This makes the role of the chief financial officer (CFO) at the second tier of the health care organization a pivotal one. With direct reports including

Figure 1.3 Organizational Chronology of a Health Care Professional



personnel in internal auditing, accounts payable, and the all-important department of accounts receivable, the CFO might have one of the smallest staffs in a health care organization but obviously one of the most important. The CFO's critical role in health care human resources management can be seen in the establishment of merit-based compensation systems related to a criteria-based performance evaluation system. Fair, equitable, and incentive-driven compensation systems, when implemented effectively, help the progressive health care organization reward good performance, thus ensuring its overall and long-term success.

Most health care organizations also have at the second tier a chief information officer (CIO). With the emergence of technology driving everything from how medical records are kept to the work of the financial audit team to Internet-based training and development, the CIO plays a pivotal role in the

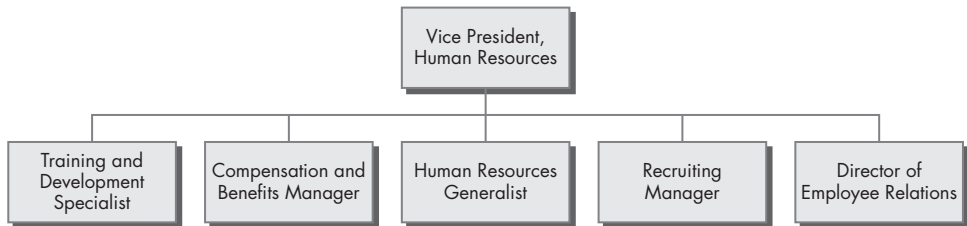
success of the health care organization, although he or she usually does not have a particularly large staff. However, with the growing demand for more information and the reliance of all staff members on reliable and accurate data, the CIO's expertise and the acumen of his or her staff can spell the difference between the organization's ability or inability to maintain a competitive edge. Accordingly, top talent must be attracted to the organization through the efforts of the organization's human resources professionals, and expertise must be afforded to the CIO's staff quickly when an employee relations problem emerges, for example, so that an equitable and efficient resolution can help maintain a vibrant flow of technology support across the organization.

Finally, the second tier of the executive cadre of a progressive health care organization must include the vice president of human resources. As you will see in the next section of this chapter, the vice president of human resources should have a complete complement of specialists and generalists that can provide counsel and leadership on the human capital issues that are the heartbeat of any successful health care organization. Furthermore, the vice president of human resources should play a critical role in the strategic planning of the health care organization, and he or she should have a keen sense of demographics and psychographics of the community because upwards of 85 percent of a health care organization's staff members live within the organization's stated service area. Accordingly, many of the employees of a health care organization are also possible patients and constituents, and certainly become ambassadors to the community in regard to new initiatives and ongoing imperatives of the organization. And, given the unique nature of the health care organization, the human resources leader fills a community role that is as vitally important as that of a public school administrator or any elected representative within the local community, involving a wide array of civic responsibilities and accountabilities.

COMPOSITION OF A PROGRESSIVE HEALTH CARE HUMAN RESOURCES MANAGEMENT DEPARTMENT

A health care human resources management department should include professionals in several essential areas (see Figure 1.4). As mentioned earlier in this chapter, a favorite cliché in health care circles is “doing more with less—to the point of doing everything with nothing”—a bromide that can

Figure 1.4 Organizational Chart—Health Care Human Resources Management Department



well apply to health care human resources management departments. It is not uncommon to see a complete human resources staff of fifteen members, including administrative and secretarial help, for a community health care organization of over two thousand employees. Although that ratio might represent a norm in health care, one would be hard-pressed to find a similar ratio in the for-profit business world. It is therefore essential that the human resources management department is well defined, well structured, and well staffed with professionals who see every day as an opportunity to increase their skill level, learn new strategies and approaches to their craft, and gain a competitive edge in the science of supporting efforts to attract, develop, and retain outstanding staff in each and every health care department.

Let's look at a general accountability overview of the key players on a health care human resources team, as represented in Figure 1.4:

The *human resources generalist* should be capable of providing counsel effectively and efficiently in most human capital management situations. Examples of this would include insight into best recruiting sources for a new pharmacist, how to best resolve a manager-employee dispute, methods for conducting a quick but accurate wage comparison, and how to best explain a new benefits package to a befuddled food services employee. Although supported by specialists, the human resources generalist is often the individual who “directs traffic,” is a “one-stop shop” on relatively uncomplicated issues, and is a “wise sage”—either individually or all at once, depending on the demand of the situation.

The *recruiting manager* has perhaps one of the most thankless tasks in health care human resources in the initial hiring process, but he or she can often garner one of the best intrinsic rewards available in health care human resources when excellent new employees prove their worth to the

organization and provide an optimal return on investment over the long term of their employment. The frustration for this individual lies in the unbalanced supply and demand paradox that exists in nursing and other areas in which specialists are at a premium because of low supply (due to an assortment of academic and career development quandaries) but in high demand (due to increasing customer-patient expectations and needs). Recruiting managers, like all professionals in the health care human resources sector, act alternately as consultants who help lead line managers, or as leaders themselves in the process of recruiting, interviewing, and selection. A recruiting manager who is truly proactive will embrace a structured selection system (such as a targeted selection system) and also will work as an educator in the active and consistent use of an effective selection and hiring system.

The *compensation and benefits manager* has the vital responsibility of making certain that market-competitive salaries are counterbalanced across the organization with incoming revenue and other budgetary requisites.

The *training and development specialist* is the gatekeeper for the future development of the organization. Whether his or her title is manager of organizational development, human capital specialist, or director of education—or whether in reality the specialist assumes all of these responsibilities with perhaps only one of the titles—this individual holds the ongoing, continuous education and professional development of the entire health care organization as the mainstay of his or her professional responsibility. Providing training, for instance, can include offering management development; developing technical proficiency; or, less obvious but very important, facilitating certification of and academic education for employees using available tuition reimbursement funds and other resources.

The *director of employee relations* is responsible for workplace dynamics, which can include labor relations issues, management-employee dispute resolution, equal opportunity compliance matters, and other direct workplace management situations.

SUMMARY

Health care organizations occupy a truly unique place in society and business in the United States. Your local health care provider is a perceived public trust, yet probably does not receive direct public financial

support. The organization itself could be a clinic, a major medical center, or an expanded suite of doctors' offices. It is likely that all three of these facilities are located nearby and could provide primary medical care for you. Accordingly, the mission, scope, and structure of a health care organization should be understood as completely as possible as the specific, singular charter of health care human resources management is assessed and developed through this text and in the balance of your professional and academic endeavors.

KEY TERMS

customer-patients

Spheres of Influence Model

nontraditional services

technical training

DISCUSSION QUESTIONS

1. This chapter included several examples of health care organizations, starting with examples from New Jersey. Cite three to five profiles of health care organizations within an hour's drive of your school or organization, and specify three to five points about each organization that make it unique.
2. This chapter discussed five dynamics that impel change in the health care environment and have an impact on the daily work lives of health care professionals at every level. What are some additional dynamics not covered in this chapter that you believe are significant?
3. The Spheres of Influence Model is a very useful graphic tool for organizational analysis. Draw spheres of influence charting the external-internal relationships between your local environment and an organization of your choice (for example, a school, team, community group, or current employer).
4. What are some additional causal relationships between the expectations and perceptions of health care customer-patients and health care professionals, in addition to the dynamics listed in this chapter?

5. Take a look at your local paper and some local television ads concerning health care, and list three to five factors in each that you believe would lead to negative or positive perceptions from customer-patients.
6. At least two hospitals or medical centers have closed in the past three years in your state or province. Research at least one and discern if some of the causes for the failure were in some way related to human resources issues (for example, poor leadership, wage problems, lack of staff, and so on).