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Aligning Human Resource Development with the Strategic Priorities of Healthcare Organizations: The CFO Perspective

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Aligning Human Resource Development with the Strategic Priorities of Healthcare

Organizations: The CFO Perspective

by

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Table of Contents

Appendices

iii

List of Tables

Abstract

The purpose of this qualitative study was to gain an understanding of how human resource development (HRD) can align more closely with the healthcare system's strategic priorities from the perspective of chief financial officers (CFOs). Five common themes emerged: (a) training is well aligned to the strategic priority to optimize clinical delivery in hospitals; (b) training is viewed as a valuable resource for achieving the strategic priorities within organizations, with CFOs rating it a score of 4 or 5 out of 5; (c) communicating strategic priorities to HRD leaders and discussing HRD's role in alignment is seen as a CFO's responsibility; (d) CFOs report consistent increases in training budgets rather than decreases; and (e) HRD leaders are not reporting evidence of trainings' value in improving productivity and profitability. Many CFOs reported that they had not thought of training as a resource for achieving strategic priorities but instead viewed training budgets as a fixed cost and not subject to change based on performance metrics. A semistructured interview format with open-ended questions was used in conformity with commonly accepted phenomenological data collection procedures. CFOs were intentionally selected as the focus of the study because they are the drivers of education department budgets and therefore have the authority to determine the viability of HRD within the organization. Eight hospital unit CFOs were interviewed. All interviews were audiotaped and transcribed verbatim. Then the transcripts were sent to all participants for review to ensure accuracy. Data analysis began with a careful and methodical reading of each transcript. CFOs' common experiences were coded by keywords. The codes were then consolidated to enable identification across all

participants. Each category was reviewed with its codes and a common thematic phrase was generated, describing salient experiences and perceptions. Findings from this study highlight the perceptions of CFOs concerning the alignment of HRD with strategic priorities within their organizations that could potentially inform HRD's critical place in healthcare organizations. Recommendations are included for healthcare HRD leaders and leaders of university programs who are interested in developing successful adult education leaders in the field of healthcare.

Chapter 1: Introduction

This is a qualitative study focusing on the perspectives of hospital chief financial officers (CFOs) seeking to understand how human resource development (HRD) can better align with the strategic priorities within their healthcare organizations. Alignment of HRD with organizational strategic priorities has always been an issue in the HRD field (Adelsberg & Trolley, 2008; Clarke, 2002; Holton, 2004). Nowhere is this more important than in the healthcare field where rigorous quality measures require constant performance improvement, while at the same time hospitals are expected to do more with less, The Healthcare Association of New York State, reported the major drivers of hospital costs include workforce shortages, pharmaceutical costs, advances in technology, insurance premiums, disaster preparedness, emergency room overutilization, and provision of care for the uninsured (Sisson, 2003). Additionally, reimbursements by third-party payers for hospital services are being reduced with each passing year (Berger, 2006). In 2001, 58% of hospitals in New York had operating losses of $343 million in revenue and an operating margin ratio of negative 1.0% across all hospitals statewide (Sisson,2003). According to the American Hospital Association's (AHA) annual report (2009), nine in 10 hospitals have made cutbacks to address economic concerns by taking the following actions:

1. Nearly half have reduced staff.

2. Eight in 10 have cut administrative expenses.

3. One in five have reduced services that communities depend on including behavioral health, post-acute care, clinics, patient education, and other services that require subsidies.

However, despite these actions, seven of 10 hospitals report a decline in overall financial health, which will impact their ability to care for their communities. AHA reported the following outcomes (2009):

1. Forty-three percent of hospitals expect losses in the first quarter, up from 26% for the same period last year.

2. Indicators of the ability of hospitals to meet their financial obligations are slipping.

3. Nearly all hospitals report that the capital situation has not improved or is still deteriorating since December of last year.

4. Since the beginning of 2008, eight of 10 hospitals have cut capital spending for facility upgrades, clinical technology, and information technology.

A more recent trend began early in 2000 when regulating organizations, including the Centers for Medicare & Medicaid Services (CMS), the Hospital Quality Alliance (HQA), and the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), made quality of care data publicly available, thereby allowing customers to make comparisons of hospital performance. The chief instrument of this effort is the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey. In January 2013, value based purchasing (pay for performance) will go into effect, whereby CMS will make reimbursement payments to hospitals based on their

achievement or improvement of specified quality measures (Lehrman, Giordano, Elliott, & Goldstein, 2010).

Another recent trend is the focus by hospitals on the patient experience. Most hospital executives have learned that providing excellent medical care isn't enough to maintain loyalty from customers. From a patient's perspective, excellent medical care is considered the minimum a healthcare organization can provide (Robison, 2010).

The 2009 HealthLeaders Media Patient Experience Leadership Survey—covering more than 200 healthcare CEOs, CFOs, COOs, CNOs, directors, senior vice presidents, and other high-ranking healthcare officials—found that 33.5% of respondents said the patient experience is their "top priority," and 54.5% said it is "among their top five priorities" (Robison, 2010).

The survey also shows that when it comes to defining the patient experience, there are widely divergent views within the healthcare industry: 34.5% agreed that the patient experience equals "patient-centered care," 29% agreed it was "an orchestrated set of activities that is meaningfully customized for each patient," and 23% said it involved "providing excellent customer service." The rest agreed that the patient experience means "creating a healing environment," was "consistent with what's measured by HCAHPS," or was something "other" than the options provided in the survey. Given the lack of consensus, many hospitals are struggling to decide what is the best way to provide it, because, after all, "if you can't define what it is, you can't provide it, and you certainly can't measure your success in delivering it" (Robison, 2010).

In spite of the lack of consensus, hospitals have sought to brand themselves in ways that promote the patient experience. A typical method is through facility redesign

such as the trend for hospital lobbies that look like those in five star hotels. Another common strategy is outreach programs such as cooking classes for patients with diabetes or lactation programs for pregnant women (Robison, 2010).

However, these amenities may not create a lasting emotional connection with patients. An emotional connection is believed by hospital executives to be the key to developing patient relationships that are enduring and profitable, and lead to better performance outcomes for the hospitals (Robison, 2010). These ongoing healthcare trends have forced hospital executives to more closely examine how HRD impacts the performance and productivity within their organizations (Berger, 2006).

According to the 2005 annual report of the American Society for Training and Development, the total training expenditure per employee in healthcare was $284, compared with an expenditure of $408 in 1999. One percent of the overall payroll in 2000 was allocated to the training of healthcare staff, compared with 1.2% in 1999. Furthermore, the ratio of trainers decreased from 1 per 405 employees in 1999 to one per 488 employees in 2000. This decrease has continued over the past decade (Sugrue & Rivera, 2005).

The declining HRD budget allocation seems to be a result of senior executives' growing dissatisfaction with current training practices. For example, training is often utilized as a solution for a wide range of organizational problems that are unrelated to employee performance (Kirkpatrick & Hawk, 2006). Passive classroom-based approaches are overused and disconnected from job-specific performance requirements. Conventional classroom training accounts for 84% of all training provided (Bates, Hatcher, Holton, III, & Chalofsky, 2001). Experts in the field report that employees are

often given too much training too soon, not allowing them enough time to absorb the material, and are provided very little support during their daily work schedules. It is estimated that classroom training provides only 10 to 15% of the skills and knowledge required to perform effectively (McGoldrick, Stewart, & Watson, 2002).

The current healthcare educational infrastructure is a good example of a misaligned system because the three major areas of education—nursing, physician, and staff and leadership development—function independently of each other and, in many cases, are separate from the overall strategic priorities of the organization. As a result, the scope of this study is limited to nursing education, staff, and leadership development.

The nursing education department is usually referred to within the hospital as the "education department" and is primarily responsible for orienting new nurses into the system. This orientation can be as short as two weeks and as long as six months. The orientation training entails both classroom and assigned floor time with a preceptor to check the skill competencies of the new nurses. Traditionally, the majority of the education department's resources are utilized in this orientation training. Another objective of the department is providing basic training requirements for accreditation (e.g. cardiopulmonary resuscitation).

Leadership development commonly targets middle management. The training topics generally focus on specific job skill requirements, general licensure requirements, performance improvement skills, and diversity. Additional courses are offered on an as-needed basis to leadership to assist with job requirements. The delivery of these courses is very decentralized; for example, diversity training is taught by the human resources department; performance improvement skills, by the operational performance

improvement department; continuing educational requirements, by the nursing education department; and finally, leadership development could be provided by any other department within the organization.

Problem

Training departments are vulnerable to reduction and even elimination because they often are not valued by the executive team. This author believes these challenges result, at least in part, because HRD leaders seem to know very little about the CFO perspective and have failed to systemically align education and training as an effective contributor to the organization's strategic priorities (Drucker, 2007).

HRD experts report that organizations spend large sums of money each year on formal training initiatives with the expectation that their expenditures will lead to improvements in performance and strategic outcomes (Dolezalek, 2005; Salas & Cannon-Bowers, 2001). However, training is often criticized for not improving job performance, and not improving profitability (Kraiger, McLinden, & Casper, 2004; Salas, Cannon-Bowers, Rhodenizer, & Bowers,1999), and is often viewed as a cost center to be downsized during less profitable times (Kraiger, 2003). Alliger, Tannenbaum, Bennett, Traver, & Shotland (1997, p.346) stated that "most training efforts are incapable of directly affecting results level criteria".

Additionally, Adelsberg and Trolley (2008) stated in their book *Running Training like a Business*:

While most business leaders are convinced that training services are essential, they harbor serious doubts about whether the training in which they invest consistently yields learning that truly helps the business. This distinction seems to

be lost on some in T&D (training and development). Its executives' growing

appetite for learning—combined with their doubts about the business value of

training—that's leading them to take a hard look at their T&D investments and

demand significant value from training services. (p. 34)

A small number of corporate training departments, such as those at Motorola,

Intel, GE, and AT&T, are thriving because they have developed supportive relationships

with senior management and have directly linked their training activities to their

organization's strategic goals (Clarke, 2002). These training departments have shifted

their focus from developing and delivering training to improving human performance to

solve organizational problems and meet strategic priorities. However, most HRD

practitioners do not know how to successfully align the training role with organizational

needs or what is involved in the process because the research lags behind practice

(Holton, 2004). Ultimately, the literature reports a general skepticism about the alignment

between training and organizational performance strategic priorities. It is this

misalignment also observed by the author that led to the research questions that frame

this study.

Purpose and Significance of Study

The purpose of this study is to gain understanding of how HRD can align more

closely with the healthcare system's strategic priorities from the perspective of the CFO.

The CFO was selected as the focus of this study instead of directors of education

departments because the CFO is the driver of education department budgets and therefore

has the authority to determine the viability of HRD within the organization. Before

examining perspectives of hospital CFOs, it is important to have an understanding of the main job responsibilities of CFOs working within healthcare systems (see Appendix A).

The knowledge gained from this study could potentially contribute to the understanding of what steps need to be taken to ensure HRD's critical place in the healthcare organization and position HRD as a significant contributor to the organization's strategic priorities, resulting in its sustained presence and successful practice.

Research Questions

The purpose of this study will be achieved through the use of the following research questions:

1. From the perspective of the CFO, what is the current priority of training in achieving organizational productivity and profitability?

2. From the perspective of the CFO, how can training departments better align with achieving organizational strategic priorities?

3. From the perspective of the CFO, what are the measures used by CFOs to evaluate productivity and allocate resources to training and development departments and programs (e.g., full-time equivalent hours, operation and capital dollars)?

Conceptual Framework for Study

Performance measurement systems, human capital theory, and strategic planning are the three concepts that frame this study. *Performance measurement system* (PMS) is a process that produces a focused set of measurable targets to evaluate the performance of individuals and organizations. The strength of this approach is that it promotes

accountability by emphasizing results that can be measured and involves key decision makers (Drucker, 2007).

Human capital is the recognition that employees are essential assets that contribute to the development and growth of the organization. The collective skills and abilities of people contribute to organizational performance and productivity. Any expenditure in training and development is viewed as an investment, and not just as an expense (Stockley, 2004).

Strategic planning is an organization's process of defining its direction and making decisions on allocating its resources, including its capital and people. In many organizations this is viewed as a process for determining where an organization is going over the next year or, more typically, three to five years. To determine where it is going, the organization needs to know exactly where it stands and then determine where it wants to go and how it will get there. The resulting document is typically called the strategic plan.

These concepts dovetail to guide this research study. Their relationship would best be illustrated by a house. The foundation of the house is the performance measurement system designed by an organization to validate the effectiveness of their strategic plan.

The strategic planning process constitutes the walls of the house because it determines the infrastructure of the organization. At the core of the strategic plan are the strategic priorities or goals. They are the compass that provides direction to the organization. Overriding both of these concepts is a roof represented by human capital theory, which demonstrates the value of HRD and the extent to which it should rely on

9

the organization's strategic plan and measurement system. These interdependent concepts guide this study.

Definition of Terms

The following terms, defined by Wilson (1999), are referenced throughout this study:

Employee training may be defined as the process of teaching employees the knowledge and skills necessary to perform their job requirements. This may be accomplished by a variety of techniques and methods. These include, but are not limited to, formal classes taught by qualified instructors, self-directed modules, attendance at internal and external seminars; and in-services by vendors. Employee training usually refers to specific skills that can be learned within a relatively short period of time. Examples include learning through demonstration how to safely set up and use a new IV pump and afterward demonstrating they can competently perform the skill to a preceptor.

Leadership development may be defined as the process of identifying employees within an organization who aim to become or who exhibit the potential to become leaders, then providing learning opportunities that prepares them to assume more responsibility.

Performance improvement is the concept of organizational change in which the organization puts into place programs, initiatives, or training in pursuit of process improvement. These results can measure the current level of performance of the organization, leading to the development of ideas for changing organizational policies and processes that can then be put into place to accomplish improved

outcomes. The primary goals of performance improvement are to increase organizational productivity in order to improve the ability of the organization to deliver its services and be more competitive.

Strategic priorities are defined as the integration of the goals for which the firm is striving and the strategies it will use to get there.

Author's Perspective

Beginning in 2004, Carla Breedlove Smith began work on the Doctorate of Curriculum and Instruction at the University of South Florida (USF). During Ms. Smith's experience as a graduate assistant, she developed an interest in conducting qualitative research in HRD.

In 2006, she accepted a position as Manager of Organizational Performance Improvement, making her responsible for the organizational performance improvement initiatives for a 225-bed, faith-based hospital. Continuing with her professional growth and development, Ms. Smith accepted the position of Director, Performance Improvement (PI), in 2009, for a 154-bed faith-based hospital located in Tampa Bay, Florida.

During her tenure as the PI director, Ms. Smith reported directly to the CFO of the hospital. Working on a regular basis with her boss, she began to observe the misalignment between middle and senior managements' views of the effectiveness of training within the hospital. During the 2009 budget cycle, the PI budget was expanded; however, the nursing education and HR training budgets were significantly cut, affecting staff hours. When questioned by the other directors, Ms. Smith did not have an answer for the discrepancy, so she questioned her boss. His reply became the basis for this study.

11

He said, "When the education and HR training show a return on investment like the PI department, I would be happy to give them the money they requested."

This and other experiences working with the CFO led to the author's following personal beliefs, which inform as well as influence the conduct of this qualitative research. First, HRD directors must awaken to the importance of aligning their initiatives with the organizational priorities as defined by the CFO and senior executive team and not developing a separate set of objectives and goals. Second, HRD directors continue to implement outdated educational models, set measurement targets that meet their needs rather than organizational needs, and remain resistant to making the changes necessary for better alignment to meet those organizational needs. Third, this resistance is the root cause of the problem and will continue to diminish HRD's effectiveness and organizational value. Fourth, HRD directors must think more critically about and begin to build best practice infrastructures. Finally, directors need to make intentional efforts to talk directly with their organization's CFO and other senior executives to understand their perspectives of strategies and processes that facilitate training initiatives that add value to organizational financial and strategic goals.

Delimitations of Study

There were several delimitations to this study. First, the data to be collected represent only the perceptions and opinions of healthcare CFOs and not those of senior or middle managers, which may differ as a result of varying experience with training issues. Second, this study has a qualitative interview design focused on analyzing executive perceptions rather than observing actual training.

Limitations of Study

  Interviewing an elite population such as healthcare CFOs may require special considerations (Selman, 1998). Attracting their attention to participate may be challenging: "elites are difficult to identify and often are inaccessible, much less open to being the subjects of scrutiny" (Odendahl & Shaw, 2002, p. 299). This limitation may also increase the difficulty of obtaining transcript review.

  Regarding the CFOs who are the focus of this study, although Erickson (1986) has indicated 10 to 15 years as the minimum time frame for expertise to develop, such criterion could have reduced the number of available CFOs within the healthcare system. Thus, the author selected CFOs that had been in their role for a minimum of two years. This criterion ensured that they had completed two budget cycles, which provided a moderate level of hands-on experience with the resource allocation process.

  Another limitation may or may not be from the small population size of four CFOs from each of the respective for-profit and nonprofit organizations. This is hard to determine because there may be unrevealed distinctions between these two types of organizations. However, to date, 30 studies of quality, cost, efficiency, and other performance measures have found no difference. For example, Sloan and Vraciu (1983) found that for-profit and nonprofit hospitals in Florida were identical in terms of profit margins, dollar value of charity care, percentage of Medicare and Medicaid patient days, and net operating funds per admission and patient days. In another study, Keeler and Rubinstein (1992) used two process measures of quality: mortality and patient satisfaction. They found, based on reviews of 14,000 medical records for five diseases in five states, no difference in quality between private not-for-profit and for-profit hospitals.

13

A study using structural measures, such as the percentage of hospitals with national accreditation and the percentage of hospitals with cardiac and intensive care, found that ownership did not make a difference (Herzlinger & Krasker, 1987). Norton and Staiger (1994) also found no difference between private not-for-profit and for-profit hospitals in delivery of uncompensated care.

Finally, Guy David (2009), of The Wharton School of Business, found after conducting an analysis of data at the state and Metropolitan Statistical Area (MSA) levels that despite the legal and ownership distinctions, there has been a growing similarity in capacity between nonprofit and for-profit hospitals over the past four decades. The driving force behind the growing similarities is increasing government regulations in the healthcare market. David stated:

> Scholars often fuse hospitals' ownership status and hospitals' objectives. Therefore, it is not surprising that to some observers, for-profit hospitals symbolize profit-seeking, compassionless, and opportunistic motives, whereas nonprofit hospitals are often viewed as community-oriented, charitable institutions. (p. 422)

However, based on this author's analysis, it is not evident that there are systematic differences between nonprofit and for-profit hospitals. This is especially true when, as is currently the case, for-profit and nonprofit hospitals treat a rather similar demographic of patients in addition to delivering similar services. The following areas will be discussed: Chapter 2: Literature Review, Chapter 3: Methods, Chapter 4: Findings, and Chapter 5: Conclusion, Implications, and Recommendations.

Chapter 2: Literature Review

Within the field of HRD there are ongoing challenges that may contribute to the misalignment of the issues the author selected to research. The definition of the field and attempts to professionalize HRD are included in this review. The differences (if any) in HRD practices in for-profit and nonprofit healthcare organizations are explored. Moreover, in this chapter the author will explore three concepts significant to HRD practitioners that frame this research study: (a) performance measurement systems, (b) human capital theory, and (c) strategic planning. These fundamentals of HRD practice are pertinent to the practitioner's relationship with senior management, which is important to alignment with organizational strategic priorities.

Defining HRD

At the present time, according to Kahnweiler (2008), virtually anyone can call him- or herself an HRD professional. There are currently no safeguards for preventing "bad HRD" from taking place, nor can someone who knows zero about HRD be prohibited from telling others that she or he is an HRD professional.

Many efforts to professionalize HRD (Kahnweiler, 2008) have been accepted by individuals or small groups of people; however, this work has by and large neither resulted in the development of a governing body to oversee the ethical conduct of its members nor in a widespread consensus among those who claim HRD as their professional identity.

Research and theory have been continually emerging from the HRD field. As the field matures, it has continued to develop its own theories and methods (Chalafsky,

2007). Monica Lee, the former editor of *Human Resource Development International* (HRDI) (Lee, 2001), argued for not defining HRD, instead allowing it to evolve organically.

Is there a difference in HRD practices between for-profit (FP) versus nonprofit (NP) healthcare organizations? Historically, religious organizations established hospitals in the United States for charitable purposes. But with the dramatic rise in healthcare costs beginning in the 1980s, healthcare providers have gradually become FP businesses. Traditionally, these different providers have been viewed within the industry as follows:

1. NP providers such as tax-exempt organizations, nonprofit hospitals, nursing homes, and clinics have missions that involve being of service to their communities and providing care regardless of a patient's ability to pay. Over the past 30 years healthcare costs have intensified, potentially threatening the survival of nonprofit healthcare providers.

2. FP providers look at healthcare as a business, with a financial bottom line, producing profits that can be distributed to shareholders. Supporters of FP healthcare believe that greater competition can produce a more efficient and less costly healthcare system.

National statistics show that two thirds of all U.S. hospitals are NP, with the remainder divided between FP and government ownership. Industry observations suggest that FP hospitals should be more efficient than NPs because they seek to make the most of shareholders' returns. In contrast, NPs should provide better quality by serving the community, providing charity care, and conducting research. However, an analysis of studies conducted over the past 20 years shows that although differences between FPs

and NPs may exist, the findings are not conclusive and in some cases even conflicting (Reeves & Ford, 2004).

Horwitz (2005) suggested that in spite of growing competition, the differences between FPs and NPs appear to be decreasing. There was no evidence that NPs treat sicker patients or differ in the number of readmissions they experience relative to FPs. Of the studies included in Rosenau and Linder's (2003) research comparing FPs and NPs, either no differences or conflicting results were found in 30% of those researching quality indicators and in 27% of those reviewing cost and efficiency.

Even those whose research has consistently found FP versus NP cost and quality differences call attention to the fact that NP hospitals have been forced to implement FP strategies to complete. As NPs join larger systems, their traditional community boards are replaced by corporate-style boards that pursue different objectives than their community counterparts. This trend also adds pressure to raise prices among NPs. In short, the literature has produced neither definitive data of differences between FPs and NPs nor conclusive evidence that there are no differences (Reeves & Ford, 2004). In addition, a review of over 11,000 periodicals did not produce evidence of any reported or observed difference in HRD practices between FP and NP organizations.

Performance Measurement System (PMS)

The author believes and key management scholars support that for HRD's continued growth and development, the implementation of performance measurement systems is required. A PMS is a process that produces a focused set of measurable targets connected to the performance improvement of individuals and organizations. In a 2006 study, Bersin asked training managers at more than 140 companies about training

measurements. Survey topics ranged from areas of training routinely measured to the percentage of training budget spent on measurement. The study revealed that many organizations continue to struggle with how to gauge the business value of training. The research data showed a significant disconnect between what organizations view as the most important and valuable areas to measure and what is actually being measured. Eighty percent of organizations reported measuring only completions, enrollments, and satisfaction of training, but only 8% measured return on training investment.

Executives consistently said the most important measures of training are the impact on employees' job skills and the business. Yet these areas were at the bottom of the metrics being measured. The research found that 82% of companies surveyed thought they should be spending more on measurement. Currently, organizations spend an average of 2.6% of their total training budgets on measurement (Bersin, 2006).

According to Bersin (2006), there is a large gap between the necessity to show business impact and the very small number of training services doing so. Most training departments lack the performance management infrastructure required to measure business impact. In fact, Bersin's research shows more than two thirds of organizations do not have systems in place for employee performance management. While HRD practitioners can measure and report on easily available data, such as completions, enrollments, and satisfaction, the current lack of integration between learning and job performance makes it very difficult to obtain data on the business impact of training.

As a result, many executives view the HRD budget as the first area to cut spending during tough financial times. According to Jacobs (2006), this vulnerability is partly the failure of HRD to be positioned as an asset in the performance and profitability

of the organization and to use standardized metrics in which to measure and evaluate the return on investment and performance improvement benefits, thus limiting the convincing evidence needed to demonstrate that training expenditures have produced a measurable return on investment for the organization.

Corporations appear to use varying ways to track and account for training costs (Bersin, 2006). Several means of tracking costs and income have been developed, including needs assessments, materials development, and production and program design time. Costs can be applied per participant or per program numbers (Bassi, 2006). However, justifying the performance improvement value that training produces is another matter entirely. While there are models for measurement, there does not seem to be any accepted standard for measuring the value of training costs in business. Other common reasons cited by HRD leadership for this gap include the fact that the benefits of training are subjective and difficult to quantify in how they may accumulate over time (Drucker, 2007).

The following section discusses the pros and cons of three strategies HRD practitioners can employ to measure performance (Drucker, 2007). These strategies are commonly utilized by performance improvement specialists within healthcare organizations.

Training audit. The HRD training personnel must set training goals; collect results from one-on-one interviews, focus groups, and interviews with management; and evaluate how close they came to meeting their metrics. If they exceeded expectations, the program is a success. If they did not meet the goals, then additional action must be taken.

A training audit is an independent investigation of a training group's objectives, strategies, and activities. Its primary purpose is to determine problem areas and opportunities and to recommend a plan of action to improve performance. It is commonly conducted by an outside consultant group hired by the executive team.

Benchmark against the best. This strategy is one of the best ways to provide a training department new direction and purpose. Benchmarking against other organizations can sometimes provide a wake-up call for the training staff. A responsible training director will then attempt to adopt other organizations' best practices. Benchmarking requires constant appraisal and evaluation of methods and resources. It is a powerful strategy toward continual improvement (Drucker, 2007).

Before-and-after metrics. Drucker (2007) said in *The Effective Executive* that for many reasons there appears to be a disconnection between training activities and desired results. If before-and-after quality cost measurements were being applied, companies could potentially determine the monetary value of quality improvement training, but it appears this is not being done in most organizations. The failure to define relevant metrics and collect before and after data continually prevents organizations from evaluating the effectiveness of training efforts.

Drucker (2007) provided the following example of a PMS: Healthcare call center managers have traditionally used before-and-after metrics to measure customer services, quality, productivity, call volume, forecasting errors, financial management, and technology integration. These measurements allow managers to see the value of the training that their companies pay for and its effect on employees' performance. A

standardized set of performance measures enables training staff to stipulate what information is required to plan, implement, and evaluate training programs.

What Should Be Measured?

To determine what should be measured, HRD practitioners should first develop an understanding of the important issues facing the senior executives of healthcare organizations. An American Hospital Association's survey (Arevalo, 2008) sent to over 1,000 randomly selected executives found that financial challenges ranked as their number one concern. The survey also found that care for the uninsured continued to rank as one of the top three issues, with 38% of respondents citing it as a major concern. Physician–hospital relations ranked third, with 35%. Other areas of concern for executives in 2007 included quality (33%), personnel shortages (30%), patient safety (29%), governmental regulations (22%), patient satisfaction (17%), and capacity (11%). The greatest changes occurred in quality and patient safety. Thirty-three percent of the executives in 2007 considered quality to be an issue compared to only 23% in 2005. Likewise, apprehensions related to patient safety increased from 20% in 2005 to 29% in 2007.

"Creating, implementing and monitoring the systems to improve quality and patient safety have become a major focus of hospital CEOs," said Thomas C. Dolan, PhD, FACHE, CAE, president and chief executive officer for the American College of Healthcare Executives. "No longer treated as a delegated responsibility solely for clinicians, the entire hospital team—senior management, physician leaders and the board—are now actively working together to improve care (p. 14).

Within the three key categories, CEOs were also asked to identify specific concerns within their hospitals. Increasing costs for staff and supplies (74%), Medicaid (74%), bad debt (73%), Medicare (71%), and inadequate funding for capital improvements (62%) were the most common examples under financial issues. Others, listed in order of importance, include managed care payments (48%), revenue cycle management (38%), emergency department (37%), and other commercial insurance (25%).

Second, to determine what should be measured requires the development of a standardized evaluation that can be used when a decision is required. This helps to improve and speed up decision making and ensures that training services address the strategic priorities. One of the most commonly used models for evaluating training in the business world, originally developed in 1959 by Donald Kirkpatrick, remains effective today (Barker, 2001).

By far considered the most popular approach (Bates, 2004) for the evaluation of training in organizations today, Kirkpatrick's (1976) evaluation model outlines four levels of training outcomes. Level one is a measure of trainee satisfaction, usually expressed on posttraining evaluation forms; level two is the measure of the improvement in the trainee's skills or knowledge after training; level three is the measure of how the employee is applying what he or she learned in the workplace; and level four is the measure of how the training program made a difference to the organization by increasing profitability, quality, productivity, or customer satisfaction (Bates, 2004).

According to Bates (2004), the popularity of the four-level model is its potential for simplifying the complex process of training evaluation. The model does this in two

important ways. First, it presents a guide for the kinds of questions that should be asked and the appropriate criteria. Second, the model reduces the number of variables with which training evaluators need to be concerned (Bates, 2004).

According to HRD scholars, Kirkpatrick's model has made valuable contributions to the practice of training evaluation. It has helped focus training evaluation practice on outcome metrics by highlighting that single outcome measures are not adequate to measure the complexity of organizational training programs, and thus emphasizing the importance of utilizing multiple measures of training effectiveness (Newstrom, 1995). Ultimately, the model has promoted awareness of the importance of thinking about and assessing training in business language (Wang, 2003). The model has also served as a useful experiment for training evaluators (Alliger & Janak, 1989) and has been the foundation from which a number of other evaluation models have been developed (Holton, 1996). For example, Jack Phillips has taken Kirkpatrick's model and added a fifth level, which he termed "return on training investment" (ROTI) (Bellack & Byers, 2001). ROTI is a measure of the financial benefits found by an organization in return for a given investment in a training program.

Critique of the Four-Level Model

The following are critiques of Kirkpatrick's model that have inferences for the limited ability of training evaluators to contribute to organizational objectives. These include the incompleteness of the model, the assumption of causation, and the assumption of increasing importance of information as the levels increase (Bates, 2004).

The four-level model presents an oversimplified view of training effectiveness that does not consider individual or contextual influences in the evaluation of training. A

broad stream of research over the past two decades (e.g., Ford & Kraiger, 1995) has documented the presence of a wide range of design and delivery factors that can impact training effectiveness. This research has led to a new understanding of training effectiveness that considers characteristics of the organization and work environment and of the individual trainee (Cannon-Bowers, Salas, Tannenbaum, & Mathieu, 1995), for example, contextual factors such as the learning culture of the organization and the level of interpersonal support in the workplace for skill acquisition (Bates, Holton, Seyler, & Carvalho, 2000). Kirkpatrick's model appears to assume that examination of these factors is not essential for effective evaluation.

Kirkpatrick's model also assumes that each level of evaluation provides data that are more informative than the previous (Alliger & Janak, 1989). This assumption has generated the perception among training evaluators that establishing level-four results will provide the most useful information about training program effectiveness. However, the data collected from this model do not necessarily provide an adequate basis for this assumption (Bates, 2004).

This discussion highlights the large gap between the research literature and the practical application in organizations, resulting in HRD practitioners working with limited measurement tools. However, because it is the only tool consistently recognized, the Kirkpatrick model is important to this study. Ultimately, measurement systems need to be built on the foundation of human capital theory, which provides opportunities for people to maximize their individual performance and the performance of the organization.

Human Capital Theory

One of the best-known applications of the idea of human capital is that of Gary Becker (1993), a proponent of the Chicago school of economics. Becker's book titled *Human Capital*, first published in 1964 by the Bureau of Economic Research, became a standard reference for many years. In his view, human capital is a means of production into which investment yields output. Output is produced from training activities that raise individual workers' productivity. Traditionally, full-time education is used as the principal example of training activities. Workers making the investment compare the attractiveness of the increase in future income to the higher present education costs.

According to Keeley (2007), human capital is an intangible asset because it is not owned by the firm that employs it. Basically, it arrives at 9:00 a.m. and leaves at 5:00 p.m. The introduction of human capital is commonly explained by the development of competence, often viewed as knowledge. Competence is expandable and self-generating; for example, as doctors gain more experience, their competence base increases, as will their endowment of human capital.

Critics of human capital theory point to the contradictions that make it difficult to measure important training functions and even criticize the central idea of human capital itself. This may be a result of executive perceptions that not all investments in education guarantee an advance in productivity. A common example is the problem of measuring both worker productivity and future income from career development. Empirical studies have suggested that though some of the observed variation is likely to be due to skills learned, the proportion of unexplained variance still remains high (Gordon, 2010).

In a critique of the term *human capital*, Stockley (2011) said the term used to describe staff and employees in businesses has changed from *personnel* to *human resources* (HR), and now *human capital*. These terms are dehumanizing. That is why some HR manager's titles include the word *people* in preference to *human resources*. The important point Stockley makes is that leaders must demonstrate by their actions that they value all their people. In summary, business leaders are recognizing that having people who are skilled and motivated can make a significant difference. To accomplish this, the organization's leaders must recognize the value and contribution of people. Treating money spent on people as an investment is a more appropriate mindset than treating these expenditures as an expense (Stockley, 2004). The successful implementation of the human capital theory within an organization requires strict adherence to a short- and long-term strategic plan.

Strategic Planning

Strategic planning is an organization's process of defining its direction and making decisions about the allocation of its resources. The author believes it is vital that HRD practitioners have a thorough understanding of the standard strategic planning process utilized by executive teams. This understanding would assist them in better aligning their services with the strategic priorities of their organizations. The following information outlines the strategic planning process that hospital executives commonly utilize.

From a business development perspective, strategic planning is the formal consideration of an organization's future course. According to Bradford and Duncan (2000), all strategic planning deals with at least one of three key questions: "What do we

do? For whom do we do it? How do we excel or compete?" (p. 8). In many organizations, strategic planning is commonly viewed as a process for determining where an organization is going over the next year (short-term planning) and over the next three to five years (long-term planning). The resulting document is called the *strategic plan*. It generally incorporates a vision and a mission statement. During this process, the executive team will analyze strengths, weaknesses, opportunities, threats (SWOT) in conjunction with specifying their organization's desired goals and objectives. In addition, they will outline the steps to be taken to attain these goals and the implementation plan of agreed upon strategies.

When developing strategies, analysis of the current state of the organization and how it may grow in the future is important. The analysis has to be executed at an internal level, as well as an external level, to identify all opportunities and threats as well as the strengths and weaknesses. Analysis of the external environment focuses on the needs and wants of the customer (Allison & Kaye, 2005).

The major challenge for organizations is goal alignment. In other words, do they fit together to form a unified strategy? Using one goal as a stepping-stone to do the next involves goal alignment (Allison & Kaye, 2005). A common barrier to goal alignment is senior management's frustration with the lack of impact training has shown in meeting the overall needs of the business. Business consultants have introduced executives to a number of training innovations, such as organizational learning, electronic support systems, virtual learning centers, distance learning, knowledge management, process mapping, and corporate universities. However, according to experts in the field, these innovations have not significantly improved organizational performance (Berta & Baker,

27

2004) because training department activities are often disconnected from organizational goals and strategies. In a recent survey, Carlson (2009) found that while 58% of U.S. training managers reported having a strategic training plan, and only 41% believed that their plan was aligned with their organization's overall strategic plan. In addition, only half of the training managers said that they were prepared to present their plan to senior management. It is not surprising that training managers said their greatest challenges were proving return on investment and gaining management's support.

Part of the challenge is that in many companies, the training director is excluded from executive planning meetings because senior managers view the training operation as a support service and not as critical to their organization's growth and development. Without access to an understanding of the organization's strategic plan, the training director will potentially struggle with producing a strategic training plan, setting priorities, and selecting projects that align with company goals (Bjomberg, 2002).

The gap between middle and senior managers appears to be a vicious cycle in healthcare systems, as evidenced by the two training models they commonly utilize: the update and competence models. The update and competence models are traditionally evaluated by CFOs to be ineffective for assisting with achieving strategic priorities (Drucker, 2007). The author has observed in her HRD leadership role that the update model is the training approach commonly used by the executive team to keep employees informed concerning operational and financial issues. The competence model is regularly used by the nursing training department to ensure the nurses meet accreditation requirements. Both models are described below.

According to Nowlen (1988), the central goal of update training is to ensure that professionals are up to date in their skills. The achievement of this goal is usually evaluated by counting the number of people involved in or assessing their satisfaction with update training (Houle, 1980). The most common formats for update training are intensive short courses, workshops led by single instructors in which professionals sit passively for long hours, or computer-based learning courses in which an instructor reads information to the participants, followed by a multiple choice quiz (Nowlen, 1988).

How can we explain the overuse use of the update model given the wide-ranging theoretical framework and innovative tools of the adult education field? The explanation, in part, may be because training practitioners and organizational leaders are not familiar with the concepts and practices available in the field of adult education (Jacobs, 2006). As a result HRD practitioners have the unending burden of keeping the staff informed of ongoing organizational knowledge using informational update methods, to the exclusion of more effective training tools (Nowlen, 1988).

The second commonly utilized HRD educational model is the competence model. The generally accepted definition of *competence* refers to characteristics that make a person capable of performing a specific task or role. To be competent is to retain sufficient knowledge and ability to meet the specified requirements of a job (Cyris, 1978).

The question for HRD practitioners to ask is why are both of these models so heavily utilized and yet viewed by those at the executive level as ineffective. Both the update and competence training models are commonly used to assist organizations with meeting strategic priorities outlined in organizational strategic plans. This seems to be the

29

case in spite of evidence that neither one of them is particularly effective in achieving performance improvement within an organization. So, why do not more practitioners examine the root cause of this gap instead of continuing to do what they have always done?

To address this concern, the author hopes to show from the following case studies that intentional design of HRD to align with strategic priorities will result in significant improvements in organizational performance. These hospital-based case studies have successfully integrated the conceptual framework concepts of performance measurement systems, human capital theory, and strategic planning to produce effective results in standard strategic priorities for healthcare organizations, including meeting or exceeding standards for patient safety and quality, leadership development, and accreditation.

Examples of Alignment in the Literature

In his book *The Fifth Discipline*, Peter Senge reflected on the challenge of aligning training and organizational strategic priorities. He began by stating,

> It is no longer sufficient to have one person learning for the organization, a Ford, or a Sloan, or a Watson, or a Gates. It is just not possible any longer to figure it out from the top, and have everyone else following the orders of the "grand strategist." The organizations that will truly excel in the future, will be the organizations that discover how to tap people's commitment and capacity to learn together at all levels of an organization. (Senge, 2006, p. 4)

He called this the "learning organization." Dr. Senge recommended building learning infrastructures based on a team learning model focused on producing "extraordinary results."

The following real-world case studies highlight the actions many healthcare systems have taken to utilize team learning models to align their training initiatives with their organizations' strategic priorities.

Case study 1: Patient safety and quality improvement. This case study is quoted from the Johns Hopkins newsletter report "Committed to Safety: Ten Case Studies on Reducing Harm to Patients," by Douglas McCarthy and David Blumenthal (2006, pp. 39–43):

Johns Hopkins Hospital is a 900-bed academic medical center affiliated with The Johns Hopkins University School of Medicine and is one of three acute care hospitals in the Johns Hopkins Health System. Two of the hospital's intensive care units (ICUs) are discussed in this case study: a 14-bed, oncology surgical ICU (known as the Weinberg ICU or WICU), and a 15-bed surgical ICU (SICU) for general vascular surgery, trauma, and transplant patients. In both, patients are co-managed by intensivist-led multidisciplinary teams. (p. 39)

Intensive care physicians at Johns Hopkins developed the Comprehensive Unit-Based Safety Program (CUSP), a model for improving quality, safety, and communication. CUSP engages, educates, and empowers staff to identify and eliminate patient safety hazards by assessing the unit's culture of safety; educating staff on the sciences of safety (e.g., anatomy of errors, systems thinking, interpersonal skills, blame vs. responsibility); identifying safety concerns; meeting regularly with a senior hospital executive who "adopts" the unit, providing support for removing system barriers and accountability for making safety improvements; prioritizing and implementing improvements

31

(teams adopt two or three simple, low-cost changes that can be made immediately and propose an additional two or three higher-cost changes that require hospital approval); and sharing success stories and disseminate results.

CUSP was pilot tested in the Johns Hopkins Hospital WICU starting in July of 2001 and six months later (January 2002) in the SICU. Its design was influenced by participation in the Institute for Healthcare Improvement's Quantum Leaps in Patient Safety collaborative. Several other safety improvement interventions were undertaken in these ICUs before and during CUSP. Unit improvement teams (physician, nurse, and administrator, plus other staff who wished to join) were given dedicated times each week to identify, educate staff and champion safety improvement efforts. Interventions suggested by the safety assessment included creating a short-term patient goals form, implementing a standardized process (known as medication reconciliation) for ensuring the accuracy of medication orders at ICU discharge, and relabeling epidural catheters to prevent misidentification. The daily goals form was instituted after a survey found that nursing staff and residents frequently did not know the goals of therapy. The form is used as a checklist during physician intensives–led rounds to identify tasks to be completed by the care team and to discover and mitigate safety risks.

The results were reported across several studies of complementary interventions that took place both before and during the time of CUSP implementation. Staff perceptions of safety culture were measured using the Safety Climate Scale, a validated instrument adapted from the aviation industry.

ICU staff ratings of a positive safety culture increased from 35 percent to 52

percent of nursing and physician staff following a six-month implementation of

CUSP in the WICU. Safety climate scores did not change significantly among

staff in the SICU, which served as a control group during this period. CUSP was

then implemented in the SICU. Six months later, ratings of a positive safety

climate had increased to 68 percent of SICU nursing staff as compared to the

baseline rate of 35 percent one year earlier.

By "adopting" the ICU, senior executives' involvement led to approval of

structural changes, including creating specialized patient transport teams and the

presence of pharmacists in ICUs. Self-reported understanding of goals of care

increased from 10 percent of residents and nurses at baseline to 95 percent after

implementing the daily goals form. One year after implementing CUSP, average

ICU length-of-stay decreased from two days to one day in the WICU and from

three days to two days in the SICU. Medication errors in transfer orders were

eliminated (from 94 percent before the intervention). The proportion of days on

which patients received all four evidence-based therapies to prevent

complications of ventilator care increased from 30 percent to 96 percent during a

six-week intervention period, resulting in an estimated 27 fewer deaths, 754 fewer

ICU bed-days, and $825,000 in savings annually.

The Johns Hopkins team reported that they had learned that promoting teamwork

and simplification of processes was key to increasing the use of evidence-based practices

associated with improved patient outcomes. "When you create a system that reliably

delivers the processes or interventions that work, spectacular performance improvement

follows," Dr. Pronovost, said in an interview for the *Joint Commission Journal on Quality and Patient Safety* (Berman, 2004).

Pronovost and Berenholtz (2004, p. 7) concluded: "It seems that knowledge of performance does not actually translate into better care unless all of the stakeholders are committed, work together to redesign the processes of care and implement those new processes consistently."

Case study 2: Nursing leadership development. The chief nursing officer (CNO) of a 250-bed, for-profit hospital made a decision to improve the quality of care and physician satisfaction in her patient care units. She felt that one of the best strategies was to further develop and improve her charge nurses' skills and job performance. As a result, she initiated a 16-week charge nurse leadership development initiative and contracted a consultant group specializing in nursing leadership development to complete the training (Smith, 2009).

The consultant's development initiative (Smith, 2009) was based on an experiential learning model in which an executive coach works with the nurses in their own work units during their scheduled shifts. The coach customized the curriculum and developed job performance improvement plans for each charge nurse. The organization selected the following measureable metrics to determine return on investment: (a) education in current ventilator-associated pneumonia and hospital-acquired pressure ulcer rates, and (b) increased nurse and physician satisfaction.

The outcomes achieved from the experiential approach were as follows (Smith, 2009): hospital-acquired pressure ulcer rates decreased 50% (2.76 to 1.39 per 1,000 patient days), ventilator-associated pneumonia rates dropped 34% (9.98 to 6.62 per 1,000

vent days), physician satisfaction improved over 21% (2.8 to 3.4 mean score based on a 5-point Likert scale), and nurse satisfaction with practice environment improved 12% (2.3 to 2.57 mean score). An annualized conservative savings from the clinical process improvements was estimated to be $1.68 million.

These case studies demonstrate the effectiveness of aligning with the strategic priorities of their organization. As previously stated, maintaining a hospital's financial viability, and therefore its ability to carry out its mission, is becoming increasingly more difficult because of many complex issues. For this reason, HRD departments need to align closely with the strategic priorities of their healthcare organizations, as defined by the senior executive team, especially the CFO. Because CFOs have the responsibility for ensuring the financial viability of their organizations, understanding what they view are the strategic priorities is essential to HRD's success, and this author believes, its evolution. In each of the case study examples, the team implemented effective actions that were directly aligned with the strategic priorities of their organizations. Both senior and middle management were working from the "same page." In addition, the actions taken were not the traditional update and competency models so commonly used in healthcare. Moreover, in all cases, the HRD trainers had developed a performance measurement system to ensure validation of their services. Finally, the performance measurement systems and strategic planning processes utilized were built on the foundation of the human capital theory, which views employee training and development as an investment in the sustainability of the organization. Ultimately, the goal of strategic priority alignment is to encourage CFOs to utilize HRD as a vital resource in maintaining the viability of their organizations.

In summary, the literature review highlighted four important issues in support of this study. First, while traditionally nonprofit hospitals are perceived as community and mission focused and for-profit hospitals are perceived as profit focused, a 20-year-data analysis indicated that although differences may exist, the findings are not conclusive and in some cases contradictory. Second, executives report the most important measurements for training are the impact on job performance and on the business; however, 80% of training leaders report measuring only completions, enrollments, and satisfaction. This shows a significant gap between what organizational managers perceive are the most important areas to measure and what is actually being measured by training departments. Third, research shows that while there are some models for measurement (e.g., the Kirkpatrick model), there does not seem to be any accepted standard for quantifying the value of training costs. It appears that both the lack of standardized performance measurements and the continued collection of only student enrollment and satisfaction data are limiting the production of necessary evidence to demonstrate that training is contributing to productivity and profitability. Finally, the author found two case studies illustrating the alignment of training services with organizational strategic priorities, including the priorities of meeting or exceeding standards for patient safety and quality, leadership development, and accreditation, thus magnifying the importance of HRD's commitment to the development and implementation of standardized performance measurements.

Chapter 3: Method

This is a qualitative analysis of healthcare CFOs' perspectives of how HRD practices could better align with the strategic priorities of their hospitals. This chapter presents the research method for this study and is organized into two segments: (a) research rationale and (b) research methods and procedures. The first segment discusses the rationale for selection of qualitative inquiry viewed through a phenomenological lens. The second segment discusses research procedures, including descriptions of the (a) research method, (b) participant selection and recruitment methods, (c) Human Subjects Committee and informed consent, (d) interview methods and questions, (e) means of identifying researcher bias, (f) data analysis methods, and (g) methods for ensuring trustworthiness.

Qualitative Inquiry Rationale

A qualitative inquiry paradigm was selected as the research method for this study because it allows for understanding the meaning that people construct from their experiences. According to Seidman (2006), the primary way a researcher can study an organization is through the experience of the individual people who carry out the processes.

In contrast to quantitative research, which examines the variable of a study, qualitative research can reveal how all the components work together to form a whole. It assumes that meaning is rooted in people's experiences and that this meaning is facilitated through the researcher's perceptions (Merriam, 1998). Merriam explained:

Qualitative research is an effort to understand situations in their uniqueness as

part of a particular context and the interactions there. This understanding is an end

in itself, so that it is not attempting to predict what may happen in the future

necessarily, but to understand that nature of that setting—what it means for

participants to be in that setting, what their lives are like, what's going on for

them, what their meanings are, what the world looks like in the particular

setting—and in the analysis to be able to communicate to others who are

interested in that setting. . . . The analysis strives for depth of understanding. (p.

1)

This research has been developed through the lens of phenomenology in which

researchers seek understanding of the world in which they live and work. In terms of

practice, the questions become broad and general so that participants can make their own

meaning. Ultimately, the goal of research then is to rely as much as possible on the

participants' perceptions of their world (Creswell, 2007).

In phenomenological research, investigators first choose a phenomenon that

seriously interests them. In the process, they reflect on core themes of the lived

experience. Researchers attempt to set aside their experience as much as possible and

adopt an unbiased view of the phenomenon. Next individuals are selected who have

experienced the phenomenon and asked to provide data through interviews. The

researcher takes this data through multiple analysis steps and ultimately develops a

description of the experience that all individuals have in common. This is the essence of

the experience (Creswell, 2007).

Research Procedures and Methods

One-on-one interviewing was the mode of qualitative inquiry chosen by the researcher. The intent was to develop an understanding of the lived experience of hospital CFOs, the meanings they make of their experiences, and the actions they plan to take. The major task was to explore the participants' responses to specific questions by having them reconstruct their experience with HRD practices.

The researcher understood that being interested in others is the key to an effective interview process. It required that the interviewer understood that others' perceptions and actions are valuable (Seidman, 2006).

Because interview research focuses on understanding experience and meaning, words rather than numbers were used to convey what has been learned about a phenomenon. In addition, data in the form of participants' own words were included to support the findings of the study (Merriam, 1998).

The procedures that were followed in identifying and recruiting participants, conducting interviews, and analyzing the data are identified below. Additionally, the steps that were taken to ensure the trustworthiness of the study are discussed.

Research method. The researcher believes that it is vital that HRD practitioners not hold the conviction that they already know why their programs do not receive adequate resources but rather seek to understand CFOs' perceptions that drive their actions. The qualitative interview was selected for this study because it effectively provides direct access to the context of the CFOs' perceptions based on lived experiences of HRD and a way to understand the meaning of the actions leading to the allocation of

resources for HRD departments, including FTE hours, capital dollars, and operational budgets.

Participant selection. Participants in this study were selected because of their span of authority and their two or more years' experience as a CFO from either for-profit or Seventh-day Adventist (SDA) nonprofit healthcare systems. Erickson (1986) has indicated 10 to 15 years as the minimum time frame for expertise to develop. However, this criterion could have potentially eliminated available CFOs within the healthcare system. Therefore, to maximize the available participant pool, the author selected CFOs who have been in their role for a minimum of two years. This ensured that they have completed two budget cycles, which would provide adequate experience with the resource allocation process.

The goal of the original research plan approved by the IRB was to interview eight CFOs from SDA hospitals located in the southeastern region of the United States. The selection of these participants was based on the researcher's familiarity and experience with, and potential access to SDA hospitals in the southeastern region of the United States. After scheduling three CFOs per protocol, the researcher was contacted by a CFO from a for-profit system who volunteered to participate in the study. Following this interview the self-selected individual then provided the researcher with three additional CFO referrals, according to the study protocol, from for-profit hospital systems. After discussing the development with her major professor, the researcher made the decision to change the protocol to interview four CFOs from for-profit and four from nonprofit hospital systems. The amended protocol was approved by the IRB. No other changes were made.

Recruitment method. To locate interview contacts, several sources of referrals were utilized, including a hospital CEO, the senior vice president of operations, and the director of human resources. The researcher had open access to these sources of referrals, who had a broad knowledge base of the healthcare industry and regular contact with healthcare CFOs regarding training.

The researcher took note that interviewing an elite population such as healthcare CFOs requires special considerations (Selman, 1998) "because attracting their attention to participate may be difficult because they [elites] are often inaccessible" (Odendahl & Shaw, 2002, p. 299). However, this was not the researcher's experience. All eight of the CFOs were accessible and cooperative with the process.

Seidman (2006) suggested that two criteria should determine the number of participants in a study: (a) "sufficient numbers to reflect the range of participants that make up the population so that others outside the sample might have a chance to connect to the experience of those in it" (pp. 47–48) and (b) "saturation of information or the achievement of a point at which the researcher 'is no longer learning anything new'" (p. 68).

Based on Seidman's (2006) recommendations from the literature, the researcher conducted interviews on a participant base of eight CFOs selected from for-profit and nonprofit healthcare systems within the United States. The goal was to interview four CFOs from the two types of healthcare organizations to explore the similarities and differences in perspectives that may or may not exist. This was intended to ensure the development of depth of experience while potentially achieving saturation of information. The first interview completed served as the pilot test for this study. The data

from the pilot confirmed the final question structure, which the dissertation committee

approved before the researcher completed the additional seven interviews. No changes

were made to the original questions; only the order was changed, along with adding a

question requesting examples for each response.

Human subjects committee and informed consent. The recruitment of

participants and the research procedures were in compliance with the University of South

Florida's Institutional Review Board (IRB) guidelines. Participants were informed about

the process and how their confidentiality would be protected, and were required to sign

an informed consent form (Appendix B).

The researcher was completely responsible for recruitment of participants. The

steps the researcher followed are now described. (a) The researcher contacted via email

and telephone call several referral sources who were personal contacts, including a

hospital CEO, a senior vice president of operations, and a director of human resources

within the SDA healthcare system. A for-profit hospital CFO contacted the author during

the research process and volunteered to participate in the interview process and also acted

as a referral source. All of the referral sources had a broad knowledge base of the

healthcare industry and regular contact with healthcare CFOs regarding training and

development-related issues. (b) The process continued when the referral sources

suggested CFOs to interview, which led to snowballing among the CFOs themselves, and

(c) the referral sources made the initial contact with the selected CFOs to gauge interest

in participation using an IRB-provided recruitment script.

When a CFO agreed to participate, the informed consent was obtained as follows:

(a) The referral source informed the CFO that the researcher had contacted his or her

administrative assistant to email an informed consent, which the CFO needed to sign and return to the researcher (this information was provided in a referral source recruitment script). (b) The researcher then contacted the CFOs' administrative assistants and provided instructions that the informed consent would be sent via email. They were instructed to obtain a signature on the form and scan it, and then return it via email to the researcher's address. They were given specific instructions from the researcher that if the CFOs had questions, they were to contact the researcher directly via email or phone. All contact information was provided in the referral source recruitment script.

Interview method. The most common way of deciding which type of interview to use is by determining the amount of structure that is necessary. At one end of the continuum are highly structured, questionnaire-driven interviews, and at the other end are unstructured, open-ended questions. According to Merriam (1998), most interviewing in qualitative investigations will fall in the middle of the continuum, with a semistructured design. This type of interview is composed of less structured questions. Usually, specific information is desired from the respondents, in which case there is a highly structured section to the interview. But the largest part of the interview is guided by a list of questions to be asked, and neither the exact wording nor the order of the questions is determined prior to the interview.

The author utilized a semistructured design because it allowed flexibility to respond to the situation at hand, to access participants' emerging worldviews, and to glean new ideas and stories that developed related to the topic.

In writing questions for this study, the researcher took into consideration the fact that the way questions are worded is crucial for gathering the desired information.

Questions were written in a language familiar to the participants, avoiding terms and concepts from the interviewer's orientation. The researcher was sensitive to the impact of particular words on the CFOs being interviewed (Moustakas, 1994). In this semistructured interview, the researcher asked participants to describe their understanding of a phenomenon.

In designing the interview guide, a two-step process was followed in which (a) the researcher designed a preliminary list of questions based on a review of relevant literature and the experience of the researcher in conducting interviews as part of the researcher's professional work and (2) conducted an exploratory interview.

On August 12, 2010, the researcher conducted an exploratory interview with the CFO of a southern-state SDA hospital. The interview lasted 60 min and was conducted in the CFO's office. Notes that were taken during the interview are detailed below:

In opening: What is your title? How long have you worked in this organization?

Answer: Chief financial officer. Twenty-one years.

Question: A report from the *Human Resource Development Quarterly* says: "[T]raining is often misapplied as a solution to a wide range of organizational problems unrelated to employee skill and knowledge deficiencies." Thoughts?

Answer: Agree. Too many decisions made on own, too much education required to prepare employees for their job, waste of time educating PRN staff.

Question: Do you agree or disagree with the following common assumptions about training?

- Training effectively "fixes" employees who are performing poorly. Supervisors assume that an employee's lack of skill or knowledge is the source of all performance problems.

Answer: Disagree. Employees are hired without appropriate level of training; sometimes education can fix the problem . . .

- Training primarily takes place in classrooms.

Answer: Disagree. On the floor . . .

Question: The purpose of training is to achieve learning objectives, not to improve performance or achieve results.

Answer: Disagree. The purpose of education is meeting the needs of the organization . . .

Question: Training is the trainer's job. Supervisors believe the responsibility for training rests exclusively with the training department.

Answer: Disagree. Buddy system that follows someone and gets signed off . . .

Question: More training is better and improves performance. Training departments are judged on the number of courses designed and delivered. Providing the "right" training to resolve skill or knowledge deficiencies is confused with the quality of training an employee receives.

Answer: Disagree. Not more training, better training is required. . . .

Question: Industry analysts report that a number of training departments have been downsized, disbanded, or outsourced because training has become too expensive or ineffective, or has been perceived to add little value to the profitability of their organizations. Is that true?

Answer: True, with the current way education is organized; not focused on objectives of the organization; healthcare nursing education not focused on overall education program; what is the purpose of the department?

Question: If you had to start a new training program in 2011, what would you do differently?

Answer: Reduce classroom time and replace with training on the floor; buddy with someone; enforce a different hiring process of hiring only staff capable of doing the job now . . .

Question: During 2008 focus week, several training departments (e.g. OPI, Patient Experience, and Leadership Development) requested substantial budget allocation dollars for 2009. What factors make the difference in which departments receive the allocated dollars requested?

Answer: Not a lot of thought is put into where to put the money that is left over; we don't have a plan for the purpose of education department. Need to change the electronic patient record . . .

Question: What is the critical success factors that enable training and development to gain influence with senior management?

Answer: Plan education program to meet the strategic needs of the organization; hit goals; reduce cost of training; set targets to align with priorities; measure; work plan . . .

Question: What is required to transform training departments into achieving organizational performance priorities?

Answer: Takes someone with a vision beyond the old classroom style; vision of what the organization needs and how to get there.

Question: What is the current effectiveness of your organization's training and development efforts?

Answer: Poor. I don't actually know how effective it is, and I don't think anyone else knows either. This is the problem; they haven't set the right targets.

Question: What are the biggest obstacles you had to overcome to achieve results?

Answer: Leadership appreciation of its value; talk the talk, but don't see its value; don't appreciate what it could return at the end of day; lack of using new skills/technology; where should it report—should it report to the clinical directors? Different training needed for management and staff (floor vs. classroom).

Question: What measurement methods are currently being developed to demonstrate the performance value of training departments?

Answer: None that I know of; measured by patient satisfaction; medication error rate; profitability, all strategic priorities . . .

Question: What do you think is the ideal training program to advance the skill, competency, and performance of employees?

Answer: Daylong overview, then move into working on the floor; in-house; internship program . . .

Question: What do you think the ideal training program would be to advance culture? What is your definition of culture?

Answer: What does your staff do when you are not there; set targets; on-floor training; learning and doing is how you change it . . .

Question: What are the fundamental areas of growth and innovation that define a learning organization?

Answer: A structured process; staff and middle management work together to learn . . .

Question: What are the lessons that you have learned about training programs that can help your organization meet its 2010 priorities?

Answer: Standard work; well planned; minimize conflict . . .

Question: How are your organization's training methods different from other hospital systems' methods?

Answer: I don't know if I can answer that; management learning is a big step in the right direction . . .

Question: What type of training and development should HRD directors have to do their jobs well?

Answer: Willing to adapt; good organizational skills; good planning skills; try new things; somebody's up on current learning . . .

Question: Finally, some training literature reports that few training directors have been able to provide senior management with convincing evidence that training expenditures have produced a performance value for their organizations. Do you agree or disagree? What advice would you have for training directors?

Answer: Agree. Set targets, having an education department is a mistake; department managers should be responsible for employee education; educators

should help management do education; implement a recording system for licensure . . .

In closing: Is there anything we missed?

Answer: No, I think your questions were excellent; they got me thinking about training in a more purposeful way. I know other CFOs in the SDA healthcare system would definitely go through this interview. It would be good for them to think about their education budgets.

The following steps were followed to finalize the interview question protocol: (a) The data from the exploratory interview was utilized to develop the initial interview protocol used in conducting the pilot interview, and (b) an academic peer and dissertation committee reviewed the transcript from the pilot interview and advised changing the order of two questions and adding the follow-up questions of asking for examples. Table 1 details the finalized interview question protocol.

Research Questions

The results of this study were achieved using the following research questions:

1. From the perspective of the CFO: What is the current priority of training in achieving organizational productivity and profitability?

2. From the perspective of the CFO: How can training departments be better aligned with achieving organizational strategic priorities?

3. From the perspective of the CFO: What are the measures used by CFOs to evaluate productivity and allocate resources to training and development departments or programs, for example, FTE hours and operation and capital dollars?

Table 1

Research Questions and Interview Questions

Research questions	Interview questions
1. From the perspective of the CFO, what is the value of training and development in achieving organizational strategic priorities?	- In general, could you describe in as much detail as possible the strategic priorities of your organization? Could you give me any additional examples? - Talk about your historical experience with training and education within your organization. - How would you rate training (scale of 1–5) as a priority for achieving productivity and profitability? Why? And how?
2. From the perspective of the CFO, how can training departments better align with achieving organizational strategic priorities?	- In what areas do you think the alignment between training and strategic priorities is currently going well? Can you provide me with examples? - What areas are not well aligned at present? Can you give me examples? - If I were an education director in your organization, what directives would you give me to better align training efforts with strategic priorities? - What obstacles would you say have to be overcome to align training efforts with strategic priorities? - In your experience, do you think there are improvements needed in employee performance from training? If yes, can you describe the needed improvements? - Can you share your future strategy for training? How will you implement it? - Some industry analysts report that a number of training departments have been downsized, disbanded, or outsourced because training has been perceived to add little value to the profitability of organizations. What would you say to them?
3. From the perspective of the CFO, what are the measures used by executives to evaluate productivity and allocate resources to training and development departments or programs (e.g., FTE hours, and operation and capital dollars?	- What factors determine which departments receive the allocated dollars requested during the budget process? More specifically, what factors do you use to determine the budget for education and training? - Some training literatures report that few training directors have been able to provide senior management with convincing evidence that training expenditures have produced a performance value for their organization. How could training directors improve their effectiveness? - What measurement methods are currently being utilized to demonstrate the performance value of training departments? What departments are responsible for measuring the value of training? Why or why not measure the value of training? - Have I missed anything that you would like to add?

The interviews ranged in length from 30–75 min. The interviews were conducted via telephone. All interviews were audiotaped and then transcribed. The IRB approved the phone protocol, because it prevented the researcher from having an on-site visit, thus limiting the disruption of work flow at the various hospital locations. An on-site, face-to-face interview protocol would have required IRB permission from each of the eight hospital's IRBs, in addition to USF's IRB. Completing all the recruitment and interviews from a remote location required only USF's IRB's approval.

In addition, the transcripts were member checked by sending the individual transcript via certified mail to each interview participant. A signature was requested to certify the transcript was complete and accurate, and return was requested to the researcher within three to four weeks of when the interviews had been conducted. A self-addressed, stamped envelope was enclosed with the transcript to ensure convenience for the participants. The participants made no changes to the returned transcripts.

Identifying Research Bias

For researchers to understand a phenomenon for what it is rather than what they perceive it to be, Moustakas (1994) stressed the importance of setting aside prejudgments. In the course of this study, four approaches were utilized to expose and minimize researcher bias.

First, the same academic peer who reviewed the question protocol interviewed the researcher. This was done using the interview protocol and querying the researcher's responses (as if the researcher were a participant), as well as by querying the researcher regarding responses anticipated from the participants. This took place before the initiation of interviews with the participants.

Second, this interview was audiotaped, and the academic peer shared notes regarding the researcher's responses. The discussion was intended to reveal differences between the researcher's thoughts on the topic and potential responses from the participants. This session served to alert the researcher to a broader range of potential aspects that might be encountered while conducting the research.

Third, the researcher re-read Merriam's (1998) chapter on interviewing techniques (Chapter 6) prior to the first interview to reestablish the sense of a researcher's responsibilities. This second review provided a reminder that the researcher's job was "to listen actively and to move the interview forward by building on what the participant was sharing" (p. 66). It provided a refresher of specific interview techniques, such as ways of probing that focus the researcher on the task of effectively engaging the participant.

Finally, an academic peer debriefing was utilized for important functions, as follows: (a) to assess bias after the interview of the first participant. This interview was conducted as a dialogue about the overall project status, the interview dialogue, and protocol effectiveness. The researcher's thinking about the topic was probed and discussed, and (b) to review the transcribed texts of the first interview to ensure that the questions being asked generated data appropriate to the research questions.

Data Analysis Methods

The analysis of data included the completion of numerous tasks performed to reduce the data to that of most importance and interest, and to identify thematic connections (Moustakas, 1994; Seidman, 2006). The researcher undertook the following steps to analyze the data (Moustakas, 1994):

Listing and preliminary grouping. The researcher used three separate readings to list every expression relevant to the experience for each individual participant. Per Moustakas (1994), this involves identifying the "interesting" statements and coding them with the keywords necessary to understand the individual participant's perceptions and experiences. Given the research questions in this study, these keywords were related to the participants' perceptions of factors, processes, and experiences that facilitated, enhanced, or inhibited training and development in creating alignment with organizational strategy. An academic peer code checked one set of interviews. The comments were determined to be functional only if referenced by the participant as contributing to strategic training and development.

Reducing (identifying) and labeling (coding). The researcher completed second and third readings of the transcripts, repeating the processes described in the first step above. The statements of interest were first identified by the second reading and then coded in the third reading, based on descriptive keywords, to help understand the participant's perceptions and experiences. Repetitive and vague expressions were eliminated.

Clustering and thematizing. The researcher categorized the descriptions of the experiences that were related into a thematic keyword that described the essential experiences and perceptions. Coding was then combined to enable the identification across all participants. Following procedures identified by Moustakas (1994), a master set of codes were created. This was done by using the Transana software system to group keywords into categories reflecting similarity and to eliminate redundancy. Each category

with its codes was reviewed and a thematic phrase generated to describe the CFOs' experiences and perceptions.

Final identification and validation. The researcher validated the coded expressions and their accompanying themes against the complete record of the research participants to ensure they were explicitly expressed. This required a final analysis of the relevant composite data. This was done for each of the themes under study. The experiences identified by the participants as essential to the interview were reviewed and recorded (see Table 2). An academic peer conducted a code check for one set of interviews.

Structural description. Using the Transana software system, a table was developed identifying the composite themes across all participants. This allowed the researcher to then construct a structural description for each CFO participant of the meanings of the individual CFO experiences. The description integrated individual experiences into a composite (common themes) of the CFOs' experiences of the alignment of HRD with organizational strategic priorities that represented the group as a whole. The descriptions included verbatim examples from the eight transcribed interviews.

As referenced previously, to accurately conduct this qualitative analysis, the researcher utilized the Transana software system. This software was selected because it was designed to allow researchers to transcribe and analyze audio data through a facilitated manual process. Other features of this software allow the researcher to identify and easily access significant portions of the audio data, organize audio files into

categories, apply searchable analytic keywords, and run reports of audio data by category or keyword.

With this set of features, Transana software supported the researcher in completing several modes of analysis. First, a transcript-based analysis was completed. Second, the audio clips were highlighted and organized. This is the electronic equivalent of cutting text documents into meaningful strips and then pasting the strips onto note cards, which are then sorted into thematic piles all over the researcher's study area. Transana also allowed the application of codes to clips, making them searchable. This enabled the researcher to look at coding patterns and time codes.

Ensuring Trustworthiness

According to Merriam (1998), ensuring trustworthiness is the overriding objective of qualitative research, encompassing both validity and reliability. The question of trustworthiness is translated as how well a particular study does what it is designed to do. Being able to trust research results is especially important to HRD practitioners, who are involved in people's lives. The nature of qualitative research means that it takes forms different from those of quantitative research.

For practitioners in the HRD field to learn about their practice of teaching adults, research studies of all types are required. To have an effect on either the practice or the theory of adult education, these studies must be rigorously conducted so they present conclusions that are trustworthy (Merriam, 1998).

Trustworthiness pertains to how well research findings reflect reality. Are investigators observing or measuring what they think they are measuring? Radcliffe (1998) offered an interesting perspective on assessing trustworthiness in research. It

should be remembered, he suggested, that (a) "data does not speak for itself; there is always an interpreter, or translator" (p. 149); (b) "one cannot observe or measure a phenomenon event without changing it, even in physics where reality is no longer considered to be single-faceted," and (c) that numbers, equations, and words "are all abstract, symbolic representations of reality, but not reality itself" (p. 150).

Merriam (1998) identified four basic strategies that were used to enhance the trustworthiness of this qualitative study: (a) triangulation using multiple methods to confirm the emerging findings; (b) academic peer code checking; (c) clarifying the researcher's assumptions, worldview, and theoretical orientation at the onset of the study; and (d) member checking.

The researcher completed all four of the identified strategies: (a) academic peer code checking: conducted by a computer lab assistant on one CFO transcript; (b) clarifying researcher assumptions: two interviews were conducted by an academic peer both prior to and after the pilot, (c) member checking: requested that participants review hard copies of their individual transcripts, sign approval and return, and (d) triangulation: compared data from the participants to determine areas of agreement, as well as areas of divergence, using the Transana coding system.

Reliability

Reliability refers to the extent to which research findings can be repeated (Merriam, 1998). In other words, if the study is repeated, will it yield the same results? Reliability is problematic in social sciences because human behavior is dynamic. Reliability in a research design is based on the assumption that there is one single reality and that studying it repeatedly will yield the same results. This is a central concept of

56

experimental research, which focuses on analyzing relationships among variables (Merriam, 1998).

Qualitative researchers seek to understand the world from the perspectives of those in it. There are many perspectives and many possible interpretations of qualitative data, therefore, "there is no benchmark by which one can take repeated measures, and establish reliability in the traditional sense" (Merriam, 1988, p. 170).

Because what is being studied in education is believed by the experts in the field to be dynamic, multifaceted, and highly contextual, replication of a qualitative study will not yield the same results. This fact does not discredit the results of the original study. Several interpretations of the same data can be made until challenged by new evidence (Merriam, 1998).

Because the term *reliability* in the traditional sense does not seem to fit when applied to qualitative research, Lincoln and Guba (1985, p. 288) suggested thinking instead about the "dependability" or "consistency" of the results obtained from the data. That is, rather than requiring that outsiders be able to replicate a particular set of results, the researcher hopes that outsiders will concur that the results make sense and that they are consistent and dependable. The question then is not whether findings will be found again but whether the results are consistent with the data collected.

In summary, this qualitative study, viewed through a phenomenological lens, describes the meaning for several CFOs of their lived experiences of HRD practices focused on describing the differences and commonalities of CFOs' perceptions. The basic purpose of the analysis process was to reduce their individual experiences regarding training to a description of their universal experience. To this end, this qualitative

research identified the phenomenon of training services in hospitals. The result was the development of a description of "what" they experienced and "how" they experienced it (Moustakas, 1994). The primary focus was on the CFOs' experiences with HRD in both nonprofit and for-profit healthcare systems. The researcher hopes the reader will come away from this study with a better understanding of the perceptions of CFOs of the alignment of HRD with organizational strategic priorities.

Chapter 4: Findings

In this chapter, the results of the eight hospital CFOs' interviews are summarized in terms of the major themes that emerged. As noted in the methods section, the researcher conducted interviews on a participant base of eight CFOs selected from both for-profit and nonprofit healthcare systems within the United States. The goal was to interview four CFOs from each healthcare system to explore similarities and differences that may or may not exist.

The first section of this chapter explores the themes identified by the four CFOs from the SDA nonprofit healthcare system. The second section of this chapter explores the themes identified by the four CFOs self-selected from for-profit healthcare systems. The third section of this chapter summarizes the themes identified by at least six of the eight CFOs and in some instances was discussed by all eight CFOs. Thus, the findings reported here represent more or less common themes mentioned by the eight CFOs interviewed. While the primary focus of this chapter is to explore common themes revealed from the interviews, the distinctively different perspectives will also be noted.

SDA Nonprofit Hospital Results

Four CFOs from various hospitals within the SDA nonprofit healthcare system, located in the southeast region of the United States, participated in this study. All of the participants were male and were recruited from four of the 22 hospitals within this system. The hospitals ranged in size from 99 to 900+ licensed beds, serving 32,000 inpatients and 53,600 outpatients annually. All of the hospitals are a part of a group of private hospitals that are owned and operated by Adventist Health System, a part of the

worldwide organization of the Seventh-day Adventist Church. The results of the four interviews are reported below:

Organizational strategic priorities. When asked to identify the high-level strategic priorities of their healthcare organizations, the participants' responses revolved around two major themes. One of the themes identified was to grow organizational market share and patient volume. Based on the researcher's experience, from a high level, this means gaining and retaining market share by attracting new optimally insured patients. This entails implementing a number of standardized strategies including partnering with physicians, because physicians are typically the source of patient referrals, and partnering with other organizations in the community to better coordinate services for patients along the continuum of care. The other theme identified was to optimize nursing clinical delivery. At a high level, this encompasses nursing clinical services across the continuum of care, including emergency, medical–surgical, and intensive care, all the way through rehab services. It also entails patient care experience that is designed to create an emotional connection with patients. The overall goal of this strategy is to deliver outstanding quality nursing care, to continually improve processes and performance, and ultimately, to achieve the highest level of patient satisfaction and loyalty. As one CFO stated:

> In simplistic terms, we have two strategic priorities. There is a lot of detail that goes into them. One of them is improve the clinical delivery product, and one of them is grow the market. Obviously, in our market we want to be a leader. We want to grow our market, and the way to do that is to attract more patients to our facilities, both from the standpoint of providing superior-quality healthcare, but

obviously, my earlier point of providing a superior patient experience. The other

major priority is to improve the product; clearly if you have a product that is

better than the competition's then, in theory, that should help you grow your

market. To go back to my early point, it is the focus going forward, not just for us,

but for the healthcare industry, whether out of OUR own initiative or the way the

industry is now going with some of the value-based measures CMS and other

payers are putting in place is that you've got to increase the quality of your

clinical outcomes, and you've got to increase the positive aspect of your patient

experience from the standpoint of our clinical nursing staff and our physicians.

Another CFO stated:

As we work toward trying to grow our market, specifically, we have our

cardiology program that we are trying to grow by bringing an interventional

cardiologist into the area to help with cath[eter] lab procedures; we are also

working on growing our GI business at our outpatient digestive health center.

All CFOs provided general and specific examples for each of the strategic

priorities. For example, one CFO stated the following concerning growing the market

priority:

An example would be a process we go through to strategically understand where

the community is growing and changing and where needs and services are not

being able to be provided in our community, and we work to figure out how to

bring resources to deploy, whether that is recruitment of specialties or

development of services within a certain geographic or based on certain

population health needs to bring to the community that people currently have to leave the community for.

Another CFO clearly demonstrated an understanding of the critical factors mandated by JCAHO to optimize clinical delivery. He stated: "We know that Medicare is focusing on core measures and patient satisfaction, so we have a number of initiatives that we are sharing with the physicians and our team to increase our HCAHPS scores."

Direct training experience. When the participants were asked to identify their training experience, their responses centered on the common theme of financial optimization within the organization. Each CFO gave examples of training to direct reports, which would be director-level employees. One CFO stated:

As it relates to my role, training is specifically related to finance[al issues]. Specifically, I work with the operations and clinical folks to ensure that our training programs balance the needs of the individual [employee] from the standpoint of giving them the best education that we can provide them. [At the same time] balancing the investment that we [are making] to get the optimal return from an educational and training standpoint.

Another CFO noted the importance of peer-focused financial training:

I do lead my direct reports through a leadership peer meeting process where we share organizational knowledge on a routine twice-a-month basis in order to make sure we have consistency and optimization of the finance enterprise within the organization.

A third participant responded: "Obviously, I have a staff that works for me, so I do more financial coaching than training with them." This participant noted another example of training, seemingly unique to his experience:

I also have facilities and security as part of my responsibilities as CFO, and I will actually go down to department meetings just to talk to them about do they know what the organizational priorities are, and do they know how to connect to those priorities. Do they know what we [executive team] are looking for and want to accomplish when we say we want to transform our culture. And then even in a facilities or security department, do you know how you can connect to improving our clinical delivery product, and do we grow our market and provide top-notch services and get their feedback.

Rate training as a priority. The participants were asked to personally rate the training initiatives on a scale of 1 to 5 (1 = low and 5 = high), as a priority to achieving organizational strategic priorities, followed by explaining the rating. The basis of this question was to determine whether the participants all viewed the value of training the same and were, therefore, working from the same "baseline" when addressing the subject. Interestingly, all of the participants rated training in the organizations as 4. As one CFO stated:

I would say we are probably a 4. You know, obviously, there is always room for improvement, and it is a dynamic process for us and we are learning as we go along; you know the organization changes, the industry changes, technology changes, clinical protocols and processes change, so over time you need to adapt and adjust your training to ensure that your training is keeping pace with other

changes that are going on in the organization. I mean to put it in scope; my

organization has about 12,000 FTEs, and about half of those are nursing staff so

obviously our nursing is our biggest labor expense, and it is also our biggest

number of staff. So, to try to have a training program that can cover that many

people, obviously, presents its challenges and its opportunities, but I think overall

we do a fairly good job.

Another participant noted the importance of balancing the costs of training:

I would say a 4. Training is critical, but there is always a balance between how

much training you can provide with the need for staff to be on the floors working

with our patients. So, trying to deal with the balance of taking care of our patients,

which is the highest priority, [ideally], it would be nice to provide a tremendous

amount of the training, but from a [staff] time [and limited resources] perspective,

it is hard to do.

Finally, a participant noted his lack of understanding the educational structure

within his organization:

I think we might be as [high as] a 3.5 to 4. I don't think we really understand how

we have built our education process. One of the challenges that we have at my

organization is we are a system and we are a separate campus. There are some

system functions that are embedded in training and education that may be

disconnected from the campus goals and priorities. So, when it comes to nursing

education, I have asked a lot of questions, and I am not sure that there is anyone

that can clearly articulate, including leadership, the educational structure of how

people are being trained here. I think we have to improve on that because the

program they are going through, if it is created at a system level, may not have a tight connection to our priorities. Now granted, they are training nurses to go from a graduate program to being bedside, so that is critically important; but if our knowledge is limited of how it is built and structured, then is it going to accomplish what we need on the other end. I am not clear we know that.

Areas of alignment. When asked about the areas where training is well aligned with organizational strategic priorities, all of the participants cited different examples directly linked to the priority of optimizing the clinical delivery. Their focus was clearly on the experience of the patient. One CFO cited IT systems training:

I would say we spent the better part of the last five years working on standardizing our clinical processes and to basically weed out our variations; so basically if you have 10 patients and they all come in for the same clinical diagnosis, then they all follow the same clinical process and clinical pathway and protocol, and educating and training our staff to leverage those IT systems and basically standardize the practice of medicine so that you don't have variations in how patients are treated. Ultimately, [this] should lead to the goal of improving the clinical outcomes of the patient.

Another CFO noted an example of improving patient satisfaction scores:

Well, one item that is front and center has to do with our patient satisfaction scores. Currently, we are below that 50th percentile and we need to get above the 75th percentile. So, what we have done is bring a patient liaison coordinator onboard and she is actively going to staff meetings and training employees on how to treat customers the right way. What is telephone etiquette, what are the

right words to say, and what do you never say; and so, we have her going around

training staff. We also have a booklet that is provided to all the employees when

they are hired into the organization that walks through key words and things of

that nature and so there is high alignment with training and achieving strategic

priorities.

Another CFO focused on improving processes:

It would be tough for me to say that it is aligned well. I think we are on that

journey to offer improvement. So, we are moving from a model that says this is

what we think we need to change, to making more intentional decisions to say

where the deficits we have within our clinical deployment exists and here is

where we are going to address the deficits with training. So we are going through

two processes that I would highlight: (a) evaluate the training process, and how

that works and so we are finding and improving that, and (b) as we look to fill

certain positions within the clinical realm we have had to expand our vision and

say [that for] some of these positions we are going to have to actively train people

versus seeking only experienced people with those acumens and skills in the

workforce development process. I would not say we are completely strategically

aligned, but we are on that journey.

Finally, a CFO focused on the alignment of training around technology:

There are a couple of things that we have done recently; we opened up our

neurosurgery operating rooms (ORs). We have what I would call ORs of the

future; they are two large ORs with an MRI in each OR. The MRI sits in the

middle and can roll left or right into the operating room. This allows

intraoperative MRI. And I think as we have a training strategy around what we have built with the ORs, it is clearly tied to improving our clinical delivery product in terms of new technology; it allows us to do very unique things. So, we create that clinical expertise and technology [that] allows us to grow in that specific service line or strategic business unit.

Areas of misalignment. Two of the CFOs felt that all areas within their organizations were well aligned, and two of them provided examples of areas of misalignment. One cited the challenges his organization was facing with developing their patient experience:

I think they are probably mutually independent training programs that may be part of the challenge. Oftentimes our training is geared more toward the clinical process side of the house as far as caring for the patient's body. Where we may be lacking is on the patient experience side of the house from the standpoint of the relationship we build with our patients in caring for the patient's mental health. I am not talking about patients who come in [with] mental health issues. I am talking about patients who come into [the] hospital in general. Many of them are probably in one of the worst situations they could be in, and you can heal their body but not necessarily heal their spirit. And we have a separate group of people who focus on patient experience, and there is probably an opportunity for us to broaden and expand that. I think we do a very good job of taking care of the patient from a clinical standpoint. I am not sure [we do] as good of a job taking care of them from an experience standpoint while they are in-house.

Finally, a CFO cited the nonnursing clinical areas as an example:

I think there are components of our organization that are misaligned. I think our

nursing team is probably more aligned than some of the other clinical areas. Other

areas that we are working through right now to develop the process [are] within

the pharmacy and respiratory, and other clinical areas, where we are looking at

what is not well developed. I think the leadership is not well organized around

these areas. We have had much more of a nursing focus as of late.

Directives for achieving alignment. When asked what directives they would

give to the directors of education and training within their organizations to ensure

training is better aligned, the first theme that emerged was senior management's

responsibility to communicate the strategic priorities and the role the directors play in

aligning training. As one CFO said, "First, we [executive team] would have to make sure

they [directors] understand the strategic priorities, so I would review them with you."

Another CFO stated:

Obviously, from a communication and alignment standpoint, there is a top-down

approach, where the CFO and COO have to set those strategic objectives for the

organization and then those need to be clearly communicated down the line to the

rest of senior management, middle management, and to the frontline staff. This is

so everyone is clear on what the organization is trying to accomplish and what

direction we are headed and why we are trying to accomplish that and why it is

important that those people are then responsible for education and training and

operationalizing the processes [and] are clear on what we are trying to

accomplish. I have worked at a number of hospital organizations, and 90% of all

problems are caused by poor communication—either a lack of communication or

a lack of clear communication—and so the biggest thing is that the CFO and COO

are very clear with their senior staff and very clear with the middle management

staff, including the director of education and training, on what the organization is

trying to accomplish.

Another CFO noted:

Depending on what strategic unit the director was in—we have about eight units

that make up our campus—I would want you to know what the vision statement

was for [that director's] unit, how that strategic business unit ties in with the

strategic goals and priorities, and how they align with the priorities of the campus.

The second theme that emerged was the need for directors to ensure that quality

training services were available for the team. Again, on this question, the participants'

focus was on the provision of a quality patient experience. A participant noted:

Because that is what your people are, they are assets to be invested in and to be

cultivated and to be grown. So philosophically the guidance that I would give to

our educational staff is that our most important asset is not the buildings we have

or the equipment we have. Our most important asset is the people that we have,

and we need to make every effort to make the best possible investment in those

people through training in order to get the best possible outcome for our patients.

So whatever that takes within reason. Again, you have to balance this against the

financial stewardship of the organization.

Another CFO stated:

Well, from an educational standpoint I would want to make sure that everyone has

access to the best education to make sure that we give our patients high-quality

services. One of the big issues that we are dealing with down the road is readmissions. So, I would want to make sure that people understand how to provide the best care and communicate in a way to avoid patients having to be readmitted. Along those same lines, management of length of stay is critical to understand the case management of each patient in order to make sure that we are managing patients as efficiently as possible.

Finally, a CFO noted that "systems should be in place that can effectively provide training for the team to build skills and competencies." He noted further:

I would encourage you not to use a cookie cutter approach where one size fits all. For example, I don't believe that every med [ical] surg [ical] nurse coming out of school needs 12 to 16 weeks of training. I believe some people only need 8 to 10 weeks, and so that is probably what I would encourage the directors to think about.

One unique difference worth noting is that one CFO described the need for a demonstration of leadership principles defined by the specific organization. He clearly articulated these principles:

And I would want the director to know that as we look at the components of team that they demonstrated the leadership principles that we want on the campus: (a) [to] show commitment to team, (b) [to] take interest in every person, (c) to actively listen, (d) to lead by continuous learning and adapting, (e) [to] know how to manage your operations, (f) [to] be visible to the team you are trying to lead and train, (g) to model the principles and behaviors and monitor performance in the lean improvement processes in their area, (h) to recognize improvement and to

describe how a team member's actions make a difference in what we are trying to do, (i) to recognize when to make decisions and when to empower team members to make decisions, and finally (j) to work with the team to understand the importance of meeting and exceeding agreed-upon goals for the department.

Major obstacles impeding alignment. When participants were asked what the major obstacles are impeding the alignment of training with strategic priorities, two themes emerged: (a) inadequate staffing and (b) the lack of a solidified training strategy within the organization. In exploring the challenge of adequate staffing, one CFO stated:

I think one of the biggest challenges we face is probably the recruitment and hiring process, and what I mean by that is there is a critical shortage of nurses in the U.S. This is not just a challenge that we deal with, but a challenge that everyone deals with. You can have the most successful training program in the country, but if you are not recruiting and retaining the best people, then there is a limit to the success you will have in your education and training program.

Another CFO noted maintaining adequate staffing was an ongoing obstacle for providing quality patient care services. He noted:

Ensuring we have appropriate staffing, for example, with nursing, we always have vacancies, and so the staff always feels as if they are working short staffed. That creates challenges in getting people the available time in order to give them necessary education. So, having appropriate staffing is critical, which means having a recruiter in place and doing everything we can to make sure we have appropriate staff.

Regarding the lack of a solidified training strategy, one CFO noted:

71

Management of lots of peoples' different objectives. I think we have a lot of

different objectives and opinions within the administrative realm of our

organization. So managing through all those different objectives, you know the

different perspectives that people have, and agreeing and coming up with one

solidified training strategy and approach. I think there is a big disconnect between

the type of training that some of our clinical leaders believe is needed and [what]

some of the administrative and financial leaders believe [is needed]. So, there has

been a big disconnect historically. It is getting better, where some leaders believe

there is a cookie cutter approach that everybody has to go through and some of

the administrative and financial leaders just don't believe that is a rational way to

look at it.

Areas needing performance improvement. Interestingly, all of the participants,

except one, who stated "I don't know," cited the patient experience as the area that

employees needed to improve on to meet their organizations' mission and strategic

priorities. Albeit, all of the participants provided varying examples, one CFO cited

personal relationship skills:

We need to recruit or need to train the people we end up with, but personal

relationship skills are probably the one area we need to improve upon. I think we

do a very good job with our clinical processes and outcomes. But I think where

we are lacking is in educating and training our staff to build that relationship with

those patients so that our patients feel that connection with our caregivers. Not

just their body was healed but also their mind and spirit were healed while they

were here.

Another CFO thought that employees needed to improve their capacity for showing compassion:

You know when I do orientation or I talk to different teams [about] our mission statement [I note that it] says to extend the healing ministry of Christ with skill and compassion and generally from a skills standpoint. I believe we have that down pat generally speaking. It's that intangible [quality] of compassion. If there is a way to come up with education that helps people become more engrained with the culture of the organization or what administration thinks that culture should be, I think that is critical and a potential gold mine, if you can make that link.

Finally, a CFO thought improving patient satisfaction scores required intense training:

I think a large part of the improvement needs to be around the patient experience. Well, as most everyone is becoming more acutely aware of, HCAHPS scores and patient experience is becoming much prominent in the way that the public, government, and payers look at care and the quality of the product that hospitals provide. I do believe a lot of the improvements to be made are on how clinicians actually communicate with and take care of the needs of our patients. I am pretty clear it is going to take some intense training and focus and change of practice to make a real difference.

Future strategy. When asked what their future strategies are for education and training within their organizations, all of the CFOs stated there was "no future strategy." One CFO stated: "Nothing new [that] I can think of at this time. Granted, education does

not report to me, so I am not plugged into everything that is on the to-do list." Another

CFO stated:

> I think that we have already rolled it out with our business plan. I think as we
>
> continue to grow and develop our training and education it will be around the
>
> business plan model of connecting people to the work that they do and how
>
> important that work is and how that work connects to our mission and vision and
>
> how they can be connected to each other and to the community we serve, in very
>
> specific areas. That becomes what drives training and education on the campus,
>
> and so I think that we have already implemented that.

Downsizing trend. When asked whether they agreed or disagreed that training

departments have been downsized because they have demonstrated little value in

achieving organization profitability, the majority of the participants disagreed. One CFO

stated:

> I disagree. As far as it contributing to the bottom line, I go back to our two
>
> strategic objectives of improving the product and growing the market. Whether
>
> through our own initiatives or whether from an industry perspective there is going
>
> to be a lot more focus, especially from CMS, in regards to paying for
>
> performance. So clearly, going forward, the quality of our clinical experience, as
>
> well as the quality of our patient experience, is going to have a bigger and bigger
>
> impact on the financial viability of the organization. And so the way to improve
>
> those two areas is through robust training and education programs. Historically,
>
> people may have questioned the value of education. I don't think that will be the
>
> case going forward. I think more organizations will make more investment in

education, specifically tied to those two points, because if they don't there will be

financial penalties associated with not performing at the same level as their peers.

Another CFO stated:

I disagree with that. You have to have a staff that is current on all education.

Especially for us to be a faith-based organization, continual training by employees

who understand our culture is critical, and that is hard to measure. So, yes, I

disagree with that.

Finally, a CFO stated:

When I hear statements like that I totally write it off. I think training has a

tremendous amount of value, so that is probably not what the problem is. And

what I see in our organization is not an issue with training from the CFO

perspective. I am not sure we are doing it in the right way. And we might be

wasting resources, but it has nothing to do with the actual training process itself. It

is who, how, and do we really understand what we want to accomplish? And if it

doesn't work, it probably wasn't designed correctly or wasn't rolled out correctly,

or what was being trained wasn't what we needed to train. But you are not going

to take a product from good to great without a true understanding of what you

need to accomplish to get that done. So, I would have to disagree with that

statement wholeheartedly because if training doesn't work, it is because it wasn't

designed correctly.

Budget allocation factors. When asked to identify the factors utilized to

determine the budgets for the training departments, it was particularly interesting to note

that all the participants cited using the labor demand model. One CFO stated:

When it comes to education and training, what we do is we have what is called a labor demand model. And so, based on our volume projections for the next fiscal year, and the types of volume that we are expecting to get, and based on our productivity standards, and also based on our turnover rate and some other variables, we come up with a labor demand model. It is basically a projection of how many nurses we will have to hire in the next fiscal year to accommodate our volume growth. It is to accommodate nurses who have separated for whatever reason and to accommodate nurses who may have transferred to a nonclinical position within the organization. And then whatever the number the labor demand model spits out ultimately feeds into our education and training program. So, if the labor demand model says that we've got to hire 800 nurses next year, then clearly we now have 800 nurses that will have to go through our education and training process.

Another CFO described the labor demand model at his organization:

We have a very specific process we go through. We look at our turnover rate, and we have a budgeted estimate based on the position of people we are bringing in. So a big factor is what we think our turnover rate will be, and then we have some training dollars set aside for each new hire and how much training they are going to need depending on what kind of clinician they are. We really don't have a formal process, except nursing has to estimate what it is going to take to get the training done, and in years where there is more training that is needed because of changes in nursing practice, they ask for more dollars and administration takes that under advisement and usually works to figure that out.

Finally, a CFO described the labor demand model in detail:

> We have developed the labor demand model that says that when you look at your staffing grid for a unit, if your census projections on a unit is 30 patients a day on average, how many FTEs will you need to have to take care of those 30 people. Then we look at what we think our turnover rate will be for the next year, and that informs how many nurses we are going to need to replace the turnover. If we think we are going to grow volume and admissions that will drive additional days, we will layer those days onto that unit. So let's say they go from 30 to 35, and then we know that census will drive new hires by X amount. Finally, we build a budget for the training of replacement nurses and the new hires between what percentage we think we will be able to hire experienced staff versus graduate nurses. This is because the graduate nurses take a lot more training, anywhere from 8 to 14 weeks, before they go on a unit, so we budget for that.

No evidence of training value. The participants were asked whether they agreed or disagree with the statement "Some training literature report that few training directors have been able to provide senior management with convincing evidence that training expenditures have produced a performance value for their organization." All of the CFOs stated that they agreed with the statement and provided various examples based on their individual experiences. One CFO stated:

> I would say that there is some truth to that. I am not sure that we do have effective metrics in place, and so I think there are some challenges in our organization as far as us being able to tie directly or to quantify the direct contribution or positive

impact that our education and training programs have on the organization. We probably have the same challenges other hospitals do.

Another stated, "I would say that is true. I have not seen any financial profitability link in a tangible format to education. I feel that it is one of those things that we have to do." Another CFO noted:

I would say that is fairly true. I think we are getting better at that, but I would agree with that. I think that they [directors] [need to] show direct links to the things that training is supposed to improve—[it] is supposed to improve clinical care and effectiveness at the bedside, or it is supposed to improve HCAHPS scores, or it is supposed to reduce turnover rates or the variety of things we are training people for. I think drawing a more direct correlation to those would be helpful.

Measurement methods. Finally, when asked what measurement methods are currently being utilized to demonstrate the value of training departments to improve productivity and profitability, all of the participants except one stated "none that I am aware of." One CFO stated: "That is a good question. I don't know of any off the top of my head." Another noted: "Nothing I can think of right now." Finally, one stated: "I am not aware of anything specific on the value of training right now being measured."

A unique point worth noting is that one CFO qualified his perceptions by stating, "I don't know [if] there is a good way of determining how well nursing training is working. Do you get what you expected? I don't know that." He then moved forward by giving examples, where he stated:

We have really good reporting. We have clinical scorecards. Again, one example

of that would be the HCAHPS scores. We are looking at those and what training

things we have rolled out to help us achieve those. And are we seeing the results

we want? So, I would say in some areas and in other areas it is not as clear. [With

respect to] specific organizational strategies, we try to make sure they are

measureable. I think we do better on those than some of the more standard

training like nursing education.

When asked the follow-up question of which departments should be doing the

reporting, all of them replied, "[C]linical training departments within the clinical

enterprise, and the performance improvement departments." It is particularly interesting

to note that when asked why they think the directors were not reporting value-based

metrics, one replied, "I don't think they know how," and another stated, "[B]ecause I

haven't asked them." The others did not directly respond to the question.

Summary. In responding to these general questions regarding their perceptions of

their organizations' training alignment with the strategic priorities, all CFOs

demonstrated an awareness of general and specific successes and challenges, and had

definite opinions on what needed to be improved.

For-Profit Hospital Results

Four CFOs participated in this study from various for-profit hospitals located in

the southeast and midwest region of the United States. Three of the CFO participants

were male and one was female, recruited from the 1,000+ for-profit community hospitals

in the country. The hospitals were midsized, ranging in size from 175- to 300+-bed

facilities. All of the hospitals were part of larger healthcare systems as large as 54 hospitals. The results of the interviews are reported below:

Organizational strategic priorities. When asked to identify the high-level strategic priorities of their healthcare organizations, all of the participants' responses revolved around three major themes: (a) achieve organizational profitability, (b) grow organizational market share and patient volume, and (c) optimize clinical delivery, including patient safety, quality measures, satisfaction, and overall experience. As one stated:

> I work for a for-profit organization, so on a high level it is to make the bottom-line EBITA [earnings before interest, taxes, and amortization] that is required to maintain the organization when it comes to investing in future capital, investing in future staff, and growing market share. And that is the high level of my job.

Another CFO highlighted the five strategic priorities of his organization:

> At a high level, we are a for-profit publicly traded company, so obviously EBITA growth, volume growth, is top of the list in the coming years. We have a lot of strategies around that. Secondly, the safety of our patients is a high priority right now. There are a lot of things going on in the reimbursement environment around readmissions to the hospital, that type of thing, the slips and falls and sentinel events that all come into play in the safety area. Quality has several different aspects, [with] strategies around getting 100% compliance around core measures. There are actually five new measures added this coming year, so there are a lot of strategies around that an organization is required to meet to achieve a high-quality rating and be viewed favorably by customers. There are a lot of public sites that

are weighing out where they want to take their care and get their care provided. And on the quality piece is patient satisfaction. A lot of different indicators that we are looking at, but the strategy is to have a superior score amongst our competitors.

Another CFO started answering by stating, "The premise for which we work is creating health for life, making our community healthy, so they won't need as much healthcare services when they get really ill. So keeping people from getting really ill is our new goal," and continued by discussing the "scorecard" and priorities measured:

We have what is called the balanced scorecard, and on it we have different sections. The first and highest priority is patient safety. We are on a patient safety journey. We have hired an outside consulting firm to assist us with that [by] reporting safety issues. The first year was [spent] making sure that reporting was increased because we wanted employees to feel safe and to know that when they report something that they know we are going to take care of it, not that they were going to get in trouble. Now that we are in year two, our goal is to get the reporting to go down because we are trying to fix issues and put processes in place that make the workplace safer for employees and for patients. The next priority on our scorecard is our patient satisfaction and that is a high priority. We want to make sure all our patients are satisfied. As you may know, Medicare is going to start paying hospitals based on how satisfied their patients are. So now it also hits our pocketbook, whereas before it was more an issue of keeping the community loyal and good customer services. Another section is financial, and of course you have to at least break even and in for-profit you have to do a little

better than that. We have financial goals we try to meet. Our company is now

traded on the New York Stock Exchange. We have investors and shareholders

that we have to keep happy. So we have a whole new set of rules and regulations

along financial performance that we have to meet. The last section is our growth

section. That is partnering with physicians and other providers to provide health

services that we don't provide at the hospital. So it is more at the outpatient

setting that we are focusing. Everyone is looking down the road to see what the

healthcare organizations are going to do. We have applied to become an

accountable-care organization with Medicare. So that will be a force for building

our network. I will say too that our mission is health for life, so we want to move

away from being the place you go when you are sick to a place you go to stay

well.

The final CFO summarized organizational priorities by saying,

Off the top of my head, I would categorize them first as safety, quality, patient

experience, and growth. We feel that as we improve our patient safety and quality

scores, patients will be happier and more satisfied with the services, physicians

will bring their patients here, employees will be happier and more engaged, and as

we do those things, the hospital will grow, [which] will result in better

profitability overall. Specifically, we have strategies and scorecard indicators

around all of those items to make sure we are achieving targets and to make sure

we are holding ourselves to a best practice standard.

Direct training experience. When asked to identify their personal training

experience within their organizations, all of the participants' responses centered on the

common theme of financial optimization within the organization, primarily for direct reports. One CFO stated:

> My training experience would come under the financial aspects of healthcare. I
> don't think the clinicians are trained well on the financial aspects of actually
> delivering the healthcare under the clinical mindset. They don't think of the cost
> of things; they don't think of the staffing that is required in a healthcare setting.
> So basically when [I am] developing budgets and they bring a clinician on into a
> management position where she has individuals underneath her, I have to train
> them on financial aspects of healthcare. I have to train them on using their
> budgets correctly. I train them on the cost of things that they utilize in the clinical
> duties and also in staffing, the people they staff for in whatever environment they
> are in, either nursing or some ancillary services in a hospital. I spend a lot of time
> educating those individuals on financials and also the budgets that are required to
> manage their departments.

Another CFO stated: "I am not directly involved in the training except for the people in my department concerning financial issues." Another participant stated:

> I feel it works well to work with management individuals on a monthly basis in
> training them on their financial acumen and also asking questions, and giving
> them help in develop[ing] strategies on making their department more efficient or
> on their staffing requirements or working together to get the correct staffing to get
> the best bottom line or EBITA for their organization.

The final CFO described the importance of aligning the financial aspects with hospital operations. He stated:

All the training I do is financial and operational. But it mostly has to do with productivity, resource management, time management, some leadership training due to my role as CFO, but [any] training I do would be financial primarily. This would only be done at the manager and director level; it would not be at the staff level.

Rate training as a priority. The participants were asked to personally rate the training initiatives on a scale of 1 to 5 (1 = low and 5= high), as a priority to achieving organizational strategic priorities, followed by an explanation of the rating. As stated in the nonprofit results section, the basis of this question was to consider whether they viewed the value of training the same way and therefore were working from the same "baseline" when addressing the subject. Three of the participants rated training in the organizations as 4. As one CFO stated:

I would personally rate it a 4. I think it is very important for people to understand what they are doing and their expectations when they are in the management position of running healthcare. I feel that these people need more training to be efficient as possible to grow the business that they are in.

Another participant discussed the importance of utilizing training for improving performance and organizational processes by noting:

I would rate it a 4. I think it is very important; I think what we find, especially with our safety initiatives, that if you are not properly trained, then everything falls through the cracks. And the other thing, we are focused on our Lean Six Sigma journey; we are trying to improve our processes and everyone has to be trained on the processes.

Another participant stated:

> I would say it is a 4. The only reason I would say a 4 instead of a 5 is because
> they really have to be shown how everything they do in the course of their day
> impact safety, quality, and patient experience. A lot of it has to do with the
> employees themselves, their attitude, their competency levels, their engagement,
> but I think the training as a core is a 4.

The final CFO, who rated the training as 5, stated:

> Well, in a leadership position, with all the strategy we execute, it is the people on
> the front line that are actually getting the work done. Providing the quality care
> and making sure things are safe, having those interfaces with doctors and making
> sure this is a desirable place to refer their patients. It is all done by the frontline
> staff. So when we roll out new things, if we don't educate the team properly, it is
> not going to get executed. It will be a management failure.

Areas of alignment. When asked about the areas where training is well aligned
with organizational strategic priorities, all of the participants cited different examples
directly linked to the priority of optimizing clinical delivery. Their focus was clearly on
the experience of the patient. One CFO cited:

> I think our safety training is going really well, as I mentioned, that is on our
> scorecard and we have different colors on the scorecard if we are meeting the
> objectives the company has put forward [to] us. Everyone thinks of green as the
> best color, but we have another level and we call it the blue level. We are actually
> at the blue level; we are doing really well with our safety and quality training. All
> quality measures are doing well. That is your core measures, readmissions rates,

and mortality rates. We are doing fabulous on all these standards that have been set for us. We are pretty much in blue for all of those except readmissions rates. So I think that training is what is turning that scorecard blue, and that has been our focus at our hospital here for the last two years or so. When we first opened this hospital, we did not have a good reputation because we did not have very good quality. So about three years ago we [hired] a new administrative team, and quality has been their focus and [is] now the number one thing we are working toward being successful at.

Another participant talked about the importance of providing bedside training to nurses to ensure optimal patient care by noting:

I think I will go back to the patient safety goals we have this year. It is going well, because I don't think a five-bullet initiative on how we are going to make patients safer is going to make any impact on frontline staff. They have to know they have to provide an aspirin to a cardiology patient on arrival within a specific period of time and that is our expectation. So they have to round on their patients once per hour and check for specific indicators that things are going well with the patient. So you have to [get] granular with the team, and the only way to do that, in my opinion, is side-by-side on-the-job training. And so what we do is we have super users that we bring up. We do that classroom-type training, and then they actually go to the bedside and do one-on-one training. They have a checklist, so we can see visibly that the things that need to be done to execute around our high-level goals are being done.

The final CFO discussed how his hospital had made a significant turnaround in the past year, specifically with new leadership, which had resulted in better alignment of training with organizational priorities. He noted:

I think it is going very well around the safety and quality for those strategic priorities, which is good, because those are our top ones. You know, we really make sure we know we are hitting all core measure bundles. We make sure [we] are looking at any safety events. We make sure we are looking at mortality rates, readmissions. Those specific things roll up to a quality and safety score, and that is where the majority of our training is occurring for the staff. It is how we impact those indicators and how we remove the variability in the process and improve the overall process by doing that to achieve our targets. So making sure staff get the needed training is very top of mind and that they have the tools necessary, and tracking it on a daily basis. One of [the] things that is done here in the area of training is every day we have a safety huddle for about 20 minutes. It is all of the leadership in the hospital [gathered] to talk about any safety events from the last night, any quality concerns, and really anything else that is on their mind and that is setting the tone and the culture for [the] hospital. And then as the directors go out on their units, [they] can use that to train their staff and make sure they are looking at the same thing we are. So, from top to bottom, we are all focused on the same things and giving them the tools and training they need to achieve them.

Areas of misalignment. There were no common themes that emerged from the participants when asked what areas are not well aligned with organizational strategic

87

priorities. Three of the participants cited examples of various types of nursing training. For example, one CFO stated:

> In most of the organizations I have been, and the one I am in now, I think that clinical nursing training has been somewhat secondary, which equates to the turnover we see. Typically what you see is the training is delinquent in this area and there is a lot of turnover in the staff because they have not been trained correctly. And what we have begun to do here is to reduce the turnover by increasing the training [for the employees].

Another CFO noted a disconnect between the information technology (IT) and nursing departments:

> I think that one of our goals that I actually neglected to mention, because it is a given, [is] there is a financial incentive to the healthcare organizations to bring up an electronic health record in several stages where you have to certify meaningful use of your electronic health record. Many organizations have already passed the first stage and [are] coming up on the second stage. Millions of dollars are at stake for every healthcare facility to certifying meaningful usage. Bringing up these systems, there is a lot of critical time lines. I have found there is a bit of a disconnect between IT and nursing. Several specific occasions where we have rolled out a system, where we have gone live with that system, provided paper documentation to the nursing staff, but we lacked the critical element of actually sitting with the nursing team and letting them put their hands on the screens. Understanding the new system that they had put in front of them, understanding any implications of you click here and not here, that type of thing, really getting

granular. We failed. We have had some lost charges; we have had some bad

rollouts. There has been a lot of failure.

The third participant stated:

We are struggling with our readmissions, and we are trying a number of new

programs that are out there to help. One of them is called the boost program.

Different ways that we are trying to train our nursing population and work with

providers outside of the hospital to manage our chronically ill patients because

they are the ones that keep coming back and being readmitted, which is not good

for them and it is costly for us. And once again Medicare will stop paying for

readmission in 2013. So that is our area that we have not been as successful as we

want to be. I think we don't have as many resources as we would like to try to

move that metric forward.

The fourth participant described the lack of organizational attention to training

staff about patient volume growth. He noted:

That is a good question. Well, one area we don't really talk to the staff about is

growth. I mentioned that one of our strategic priorities is growth and building the

volume of the hospital. And I do think that as we work on our top priorities that

growth will come, but I don't know [what] the staff at the employee level really

think about their responsibility for growing the volume. So, we don't talk to them

a lot about it. We don't talk to them specifically [about] what they can do as far as

training goes. We don't train them on things you can do to find [out] if the

physician is happy [or] to find out what growth opportunities there might be. We

don't really do a good job at that.

Directives to achieve alignment. As with the CFOs from the nonprofit hospitals,

when asked what directives they would give to the directors of education and training

within their organizations to ensure training was better aligned, the common theme that

emerged was senior management's responsibility to communicate the strategic priorities

and outline the role the directors play in aligning training initiatives. As one CFO stated:

> Well, I think I would sit down with all of our educators and show them our road
>
> map of what we are striving for and how [their] area of expertise fits with the
>
> overall direction of the organization. What can you provide for our staff that will
>
> assist us in turning our matrix blue on our scorecards? We have different types of
>
> educators—diabetes, labor and delivery, ICU, OR. Each one has their own
>
> specific matrix. For example, OR educators have SCIP measures that make sure
>
> you [the nurses] don't get infections for your surgical patients. That was one of
>
> the things we had struggled with, so we put a big team together and now we have
>
> been at 99 to 100% compliance.

Another participant noted:

> I would make sure that you [the director] were in frequent communication with
>
> the senior management team, chief medical officer, chief nursing officer, me, and
>
> the CEO to make sure that you understand completely what the strategic priorities
>
> are and what the expectations are. I think it is one thing to see a list of strategic
>
> priorities but that I would make sure you know what your role in that was. To
>
> make sure that training we are offering to our employees, whether it is a physician
>
> luncheon or whether it [is] formal training, or if we are sending people out of the
>
> hospital to make sure that any education we provide can somehow be tied back to

one [of] the strategic priorities. We can do free education for the employees, but I don't know that we make sure that all the education ties back specifically to one of our strategic priorities. The direction would be that you make sure any training and education you offer can somehow be tied back to helping us achieve our goals, and I think that it would be helpful to point out as we offer that training, here is what the hospital is working on and here is why we are offering this education.

The third participant added to the consensus by stating, "First, I would talk with the director about our organization goals and how they can help us meet those goals with their training initiatives" and then continued with additional advice by noting the need for directors to ensure that quality training services are available for the team:

We continue to pull our nurses away from the bedside and into the classroom for training. [I believe it is best to], wherever you can, take the training to the bedside. [Another strategy is to] identify a handful of super users, take them out of the mix of nursing care, get them up to speed, and then go with the nurses side by side on the job training and make sure they roll these things out effectively. First of all, let's get out of the classroom and get to the bedside, and let's train at the bedside, and secondly, do not assume anything is working the way you think it should, just because you have identified 4 or 5 super users and they are supposed to do this on this day. Instead you have got to put your hands on it as an educator, you [have] got to see it in action, you [have] got to be able to validate that the training is occurring, and that it is occurring effectively. And, I would add as a third set of advice, go to the end users, go to the nurses, and get their feedback

about the training in the end and make sure your perception of quality training is the same perception that they have as the one that is being trained.

The final CFO talked directly about the importance of aligning training with the profitability priority, he stated:

You have to understand that training requires a lot of staff time, which is a cost to the organization, so as a director, how you can most sufficiently get the staff trained with using minimal amount of staff time is going to be the thing to really look at because every hour used in training is an hour in cost for the organization. That is not an efficient use of cost in the short term, but in the long term it is.

Major obstacles impeding alignment. When asked what the major obstacles impeding the alignment of training with strategic priorities are, all four CFOs stated loss of productivity, referring to the removal of the staff from bedside patient care to train them. In exploring this challenge one CFO stated:

The major obstacle to overcome is the cost of the staff time involved, knowing it is going to cut into your bottom line EBITA number. So that everyone has to agree that we are going to use a percentage of our earnings to train staff, just as we use a percentage to buy capital and equipment for that hospital or facility.

Another participant noted:

The hard thing for a CFO to admit is the productivity piece. Every time you are training people, even at the bedside, there is a loss in productivity. And so, it is that constant balance of the return on investment for training and the lost productivity. That is the biggest obstacle. You know, it is being able to afford to do the training, and I would say, secondly, if you have a plan to afford it, being

able to track effectively how much classroom training there is, and to be able to

quantify what is the return on investment for that training. You know, for me, I

guess it is a CFO answer, but it is being able to afford to do things the right way

in the short term. There is always the long-term implication if you don't train

people in the right way, but even in the short term it becomes very difficult

financially to make that investment.

The third participant started by stating, "There is always the financial question of

how much as an organization you are willing to invest in training" and then continued to

explain:

It is not just the salary of the person doing the training; it is all the hours the

nurses spend going to training. When they are off the floors you have to backfill

those hours so you can run the hospital and take care of the patients. So, the issues

are (1) getting the funding, making sure you have the budget to provide the

training, (2) making sure you have enough bodies. Where we are there is a

nursing shortage. We have high turnover, and it is hard to keep our hospital

staffed, especially in the winter. So it makes it hard to add training to that burden.

The final CFO also spoke about the barrier of lost productivity; however, he went

on to describe the importance of not limiting training initiatives because of financial

concerns. He noted:

So there may have been barriers in the past to just quickly say that we don't have

the money or we can't take that much time for education. Those can be barriers

that can really hold back the education director if they don't know how to voice

those issues and work through them. It is really easy to say they don't have the

time or money to do it. But if you look at those as questions to be answered and rather than barriers, then you can still do a lot of those thing without having a huge impact financially. Barriers in the past have been just not knowing really what they had the latitude and the freedom to do and maybe having so much on their plate that they didn't feel that they could be proactive with our education. But we are in a better place now with that than we were. So, I would say financial resources and time have been the barriers.

Areas of performance improvement. No theme emerged when the CFOs were asked what areas the employees needed to improve on to meet their organizations' priorities. Two CFOs cited clinical nursing skills, and the other two participants did not directly answer the question. The first participant stated:

Yes, we have a third floor that is surgical patients. On our fourth floor are telemetry patients on heart monitors, and on our fifth floor we have telemetry and heart patients. We fill up our fourth floor and we have to use the fifth floor as backup rooms for heart patients. What we are finding is we don't have enough nurses with telemetry skills to take care of our high volume of patients. We have the equipment to put on them, but we don't have the skills of the nurses to be able to take care of the patients to make sure that we keep them safe. So we have had to train our regular nurses and ask them if they want[ed] to go into what we call a bridge program where we say we are willing to put the money and invest the time if you guys will be trained as a telemetry nurse. They are harder to find because of their special skill set. So that is one area where we have tried to get contract labor or we are training in house. I can give you another example. Sometimes our

94

nurses on the floor are not comfortable taking care of more difficult patients that

might be in the ICU but really don't need to be in the ICU; they should be going

to the floor. But maybe our nurses aren't as comfortable, so getting each nurse up

to the level they need to be comfortable to take care of the patients. We might be a

little bit behind, so we need to be spending more time, effort, and money to get

our nurses up to the skill level necessary to take care of our patients.

Another CFO stated:

You know, I would say we just had a mock JCAHO survey, and I was really

shocked at the amount [of] basic cleanliness issues we have across the facility.

And so, I know you can go through the list of new-hire training with the nurses—

we have core competencies, we have yearly checkup where they go in to keep

them up to speed on infection control issues and safety issues and that kind of

thing. But the proof is in the pudding; I was very disappointed in some of the

things, just the cleanliness issues that we came across in getting ready for the

JCAHO survey.

Future strategy. No theme emerged when the participants were asked what their

future strategies are for education and training within their organizations. Two of the

CFOs said they could not think of anything. The other two participants gave varying

examples of future strategy. One participant noted:

The future strategy for my organization is that CMS is going to be grading people

on customer service at a hospital level through HCAHPS, also on some clinical

issues, so there has to be more training involved so when patients leave the

hospital they will give it good marks because there is going to be reimbursement

95

tied to it. People aren't seeing it yet, but they will see it this next year, and that is going to be a big issue in hospitals going forward. That is coming in October 2012.

The final CFO described his future strategy as focused on rolling out electronic health record training for the outpatient clinical staff:

One of the things that are interesting that we are doing is we are rolling out e-clinical works to our clinical practice environments. And you know we have clinics that are 20 miles away where we are going to have to roll out these systems that bring all the clinics up to the same standard of patient care. It is a big task; we are fully funded for it. We actually have some nice grant monies. Basically, it is the electronic health record for the practice environment.

Downsizing trend. As with the nonprofit participants, when asked whether they agreed or disagreed that training departments have been downsized because they have demonstrated little value in achieving organization profitability, the majority of the participants disagreed. One participant stated, "I have worked with multiple organizations, and I have seen nothing but growth in training." Another CFO stated:

I would say that is not the case here. We have actually added a resource to the education department. We can have wonderful things going on in the quality department and with patient safety and satisfaction, but if we are not able to train our staff on what is happening there we are not going to get very far. I think this organization has recognized that. The position was open but was filled internally, with never a thought to that position that we could do without. So it has not been a concern here. We have not downsized. In fact we have added to the department.

Another CFO noted:

> That is totally false. If you have ever taken over an organization, the high turnover
> is mainly due to training and the clinical environment they are in. So I have been
> there, and I have seen that you can reduce your turnover costs. I can understand if
> the organization is operating profitable and everything seems to be going well so
> putting money into something that is already going well doesn't seem very
> profitable. But like I said, CMS will be reducing reimbursement on facilities that
> don't have high scores this year. So people are going to find out pretty quickly.
> Well, they should be seeing their surveys already; they have been surveying for a
> year now to see if they are in that position. I think you are going to see training
> costs and departments go up to tell you the truth, with more people putting
> emphasis on training.

The final CFO agreed with the downsizing trend but continued by talking about
the importance of not decreasing training if hospitals want to achieve their goals. He
stated:

> Well, I would say that they have seen a lot of that. I know that we have probably
> less educator positions in our hospital than we did two years ago. So, I think the
> first part of the statement is true that there has been some downsizing in training
> because it is an easy, quick way to save money. However, I think in the long run
> we will find out it is not the right thing to do and it will cost us in the end.
> Because what is happening in healthcare, we can't afford the crazy costs that we
> have in the U.S. And this is bankrupting the economy, and we have got to do
> something different or it will spiral out of control. I think Medicare is right in that

97

they are trying to push all hospitals to go to quality and cost effectiveness and to do that you have to to have the best trained staff. You have to be the most efficient, and you have to standardize processes to eliminate variation so you have good outcomes. That is what will eventually end up saving the dollars. So I think training is very important, and I don't think it is something that we should be skimping on.

Budget allocation factors. When the CFOs were asked to identify the factors utilized to determine the budget for the training departments, particularly interesting to note is that the majority of the participants cited using "run rates" to establish a baseline, followed by analyzing costs of proposed training for the upcoming year. One participant explained how he defined run rates:

Generally the education budget is determined, at least initially, like every other department. We take a run rate of what they have actually required over the last 10 months, and we look at staffing and supplies and any resources they might have used and we use that as a starting point. And we annualize that and say this is the starting point for next year's budget. At this point a preliminary budget goes out to the director group, and they look at all the details, including education. And they say this was my run rate, but I am going to be higher here and you can take this out. And they have the opportunity to give input and say for my department either it will be the same, or here are some of things that are going to change and I need to move some dollars around. Generally, departments need to hold their departments flat. We are not in a position where really we can add a whole lot. Even in the education department, I would not be able to add to the budget, but I

98

do give them input on how they want to use their resources. So we can move

dollars around to fit what they want to do the next year. Then I have to look back

and say, does this get us where we want to be? If it doesn't, then I go back and

say, where can we look for opportunities to improve the bottom line?

Another CFO cited:

Well, that is a hard one, because the budgeted dollars for training, usually you

start with the base you are already at. What I do also, you look at what

departments you are going to be training and how many hours you are going to

allocate to training in the different clinical areas, because if you are going to put

in let's say a different course that is going to take this many hours, I have to put

that cost into the revenue or nursing department that you are going to be training.

So the overall education department should stay relatively the same; it is the cost

of the training hours that will go up. So you have to work with the department

head doing the education to find out what kind of programs she is going to train

on, and how many hours is it going to take, and how many staff members are

going to be taking part in that training to come up with a good budget.

The third participant noted:

You know, I look at them in strictly budgetary terms as a fixed department,

meaning you look at run rates first. Then you have to decide how much training

you have coming up in the next year, how many systems you might roll out, what

is the growth in your FTE population that you are expecting; that is all modeled in

the budget process. At the end of the day, at least in the small facilities I have

been in, you know, you typically have 1 to 2 FTEs as trainers, and they use the

super-user model with the nursing leadership to roll out training. From a budgetary perspective, I think of it as a fixed department. Some point in time and a good case is made that you were going to have a heavy year, you would cross that threshold to say, we can't do it with two people; we need a third trainer. So that is kind of my logic as I go through the budgeting process.

The final participant cited the labor demand model:

One of the things that we do is we calculate what we think our turnover is going to be, and as I mentioned before, every new employee goes through three days of training, but that is just for people who have been in a hospital system. The thing I haven't mentioned is over the last 18 months we have been hiring new graduates right out of nursing programs. A lot of hospitals won't do this because these nurses have no experience. So one of the things we put in our budget was to hire 25 new graduates last winter, and they take about a 12-week time period to orient. So it is a big investment in terms of time and dollars because as you have these student nurses who can't really take care of patients, so they are shadowing other more experienced nurses. So you have the cost of paying them; and you still have to hire your regular nurses to take care of the patients, so we do budget for that. We budget so much for turnover, and even an experienced nurse when she comes in has to go through a two- to three-day orientation to learn how to do things at our facility. So we budget those costs in. And then we add in special projects. For instance, we are getting ready to roll out an electronic medical record for physician orders. So that is a new software program. So I have budgeted around 200,000 dollars this winter to train every person in our hospital to learn how to

use the new computer system. We have a lot of that going on. So we kind of

budget for the overall turnover training, new graduate training, and then special

project training. That all gets budgeted by department based on how many hours

per person we'll need.

No evidence of training value. The participants were asked whether they agreed

or disagreed with the statement "Some training literature report that few training directors

have been able to provide senior management with convincing evidence that training

expenditures have produced a performance value for their organization." As with the

nonprofit participants, all of the CFOs agreed with the statement, and each of them

provided examples based on their individual experiences. One CFO stated:

> I would agree with that completely, and I don't think it is any fault of her own. I
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> think it would be very hard to say here is all the training the department produces
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> over the year, and here is the result. There are some indirect ways we could make
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> some correlations through improvements in a particular area. If there was training
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> we put in place where we are trying to target one particular deficiency and
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> problem, she could probably do that on a case-by-case basis for some things, but
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> overall it is kind of like marketing—you could spend marketing dollars and you
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> don't really know if that money is having an impact or if your volumes are up for
>
> a different reason. I know we have not ever really asked them to tie back a return
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> on what we are doing in that department. I can't think of any specific examples
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> where we have done that. You know, as I think through how she would do that, I
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> just don't know how she would do it. It is probably one of the reasons I don't
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> want to ask someone, you know, I need you to show me quantifiable results of the

education you are doing, when I don't know how she would do that. And that is

probably lacking more on my part than her part. I've seen her in the past put

together a training module in a couple of weeks. It goes online in a couple of

weeks, and we say that everyone has to have it within 30 days. And she does a

great job with that. But overall performance of the whole department, to be

honest, I haven't actually thought about it really. I don't think it is on the top of

any CFO's mind to say, how am I going to get a return out of my education

department? Generally, you are not talking about a lot of expense and a lot of

dollars. It hasn't been a huge cost center where I thought I have to demand some

performance out of this department, and, honestly, even as a CFO, I haven't

thought I really need to know what I am getting for this. It just hasn't been one for

me.

Another participant noted:

I agree. Few training directors produce measures of training performance value.

Well, that comes down to outcome studies. Most executives seem to believe that

education departments can't give you outcome studies on what kind of cost

reductions or what kind of profitability that they have increased. What they

should do is a survey of the actual positions and find out if they would have left

that position the training was not being done in and have some kind of outcome

forecasts for turnover rates based on the training they get compared to their

competitor in the market that might be doing more training on the subject they

need to keep their clinical skills up or to add a new service. I would do an

outcome study and do some surveys on the market on why they stay at an

organization and how important is training to them to stay at an organization. And then I would go and survey my own staff for the importance of training for why they staff at the organization. I think that would show a lot of information to the administration that our training really makes a difference. Our turnover rate would be 10% higher if we didn't do the same sort of training that our competitor does or doesn't do across town.

Another participant noted:

I could probably see that. They have to be trained up themselves to do this. I guess there is not a lot of performance results being reported. Right now, I know our training is effective because you get a sense as to how hard they [training staff] are working and whether they are effective. You know that is an interesting question. I think a lot of times it is just kind of a hip shot kind of feeling whether you have an effective person doing things in the right way or not.

The third CFO gave a specific example of areas of training that were measured. However, she agreed that on the day-to-day training the directors were not reporting results:

That probably is true. I don't think that we really quantify the benefits that we get from the training. I guess one of the things we get from the computer training is the government is paying everyone to go to electronic record training. So we have been able to quantify the ROI, as far as we got paid a lot of money this year from the government to go electronic. So we have been able to calculate this is the investment in the hardwired, and this is the investment we made in training hours, and this is the money we got from the government. So we have been able to show

103

a profit. But I think on the day-to-day stuff we don't do a real good job. One of

the things we have tried to do with our nurse grad program is quantify that,

saying, OK, this is the amount we spent investing in this training, but because

they are brand new they may be making 5 to 10 dollars less per hour than an

experienced nurse so as time goes by we can make up that investment because of

the lower rate. So we have tried to do some of that analysis as well.

The final CFO agreed with the statement and then provided advice to directors on
how to improve their value to the organization:

I think maybe some of that is true. I think that one of the things we are trying to

do right now is look at our costs. So one of the things we are doing is tracking our

diagnostic costs and malpractice costs. I think that if you are reducing variation

and improving your results, you will have less payout costs to patients. So I think

that is one of the ways directors can improve their value to an organization.

Measurement methods. Finally, when asked what measurement methods are
currently being utilized to demonstrate the value of training departments to improve
productivity and profitability, all of the participants made a statement that when
paraphrased went like this: "We don't have any that I know of." One CFO noted, "I don't
know we have any measurements to tie those things [training and strategic priorities]
together." When asked which departments should be reporting, he answered,
"Administration and the education department," and finally, when asked why he didn't
have measurements in place, he noted:

Again, I for one, I have never thought about how I am going to tie the two things

together. I don't know how to do it, and I am not going to ask someone to do

something I don't know how to do. Even given the result, I am not sure what I

would do with the information as the CFO. I think it is more of a CEO or CNO

[chief nursing officer] area to talk about that. I just have never had the thought

about how we could tie education back to our strategic priorities. You know it is

not something that stands out to me as an opportunity for a return. But I like the

idea of thinking of it that way.

Another participant stated:

I have never seen an organization use any measurements to evaluate the training

department in any facility I have worked for, which is bad. If I was the director of

a training department, I would sure try to let everyone know the reason my job

existed.

When asked which departments should be measuring, he answered: "I think the nursing

department and any clinical department that is getting training should be doing an exit

survey to find out how valuable that training was for their staff." And, finally, when

asked why he doesn't have measurements in place, he stated:

You know, I don't think they have ever had that mindset that they need to have

measurements. They are there knowing that there has to be some sort of training

on different clinical issues and they have to have so much training on this or that

by policy, and I don't think they really realize that people can cut their jobs. I

don't know.

The third participant stated:

No, they are not really reporting anything to me, probably because I am not

asking for it. I mean, I am really embarrassed that I don't have a more specific

pulse on this. We know it is important, yet there are so many fires that you put out

that I have to say it is fairly low on the priority list, which kind of contradicts

what I said earlier about training being really important. When I made that

statement I really meant it. I mean an effective rollout of all the things we are

doing and making sure all our patients are safe, because our nurses are up to speed

on things they need to be.

The final CFO stated,

We don't have anything right now. I guess I need to put that forth to our systems

office, and maybe there is something going on that I don't know about. I am not

aware of anything." When asked why, he said, "I am not sure. I have been here a

couple of years, and I really haven't thought of it that way. I don't know. It is a

good question.

Summary. In responding to these general questions regarding the perceptions of

their organizations' training alignment with the strategic priorities, all demonstrated an

awareness of general and specific successes and challenges, and they had definite

opinions on what needed to be improved.

Composite Themes From CFO Interviews

In responding to these general questions regarding their perspectives of the

alignment of training with the strategic priorities within their respective hospitals, all of

the CFOs demonstrated an awareness of the big picture: They were aware of both specific

and general successes, processes, barriers, and budgetary allocation systems. They had

definite opinions on the value and effectiveness of training, and showed the capacity for

reflection on areas needing improvement. As one CFO stated, "I haven't thought about

the alignment of training with priorities before, but I like thinking about it that way." All the CFOs had similar definitions of the term *quality,* meaning that when they are striving to improve quality, they are working toward the shared goal of optimizing their clinical delivery, resulting in a superior patient experience.

The third section of this chapter summarizes the composite themes mentioned independently by at least six of the eight CFOs and, in some instances, was discussed by all eight CFOs. Table 2 outlines the thematic subsets (keywords) identified during the labeling and coding step.

Table 2
Themes by Keywords

Keywords	Nonprofit results (*n* = 4)	For-profit results (*n* = 4)	Interview themes (*n* = 8)
Organizational strategic priorities	All CFOs stated the high-level strategic priorities are (a) grow organizational market share and volumes and (b) optimize clinical delivery and overall patient experience.	All CFOs reported the high-level strategic priorities are (a) achieve organizational profitability, (b) grow organizational market share and volume, and (c) optimize clinical delivery and overall patient experience.	All CFOs cited the strategic priorities of (a) optimize clinical delivery and (b) grow market share and patient volumes.
Direct training experience	All CFOs noted their direct training experience was focused on financial optimization within the organization.	All CFOs noted that their direct training experience was focused on financial optimization within the organization.	All CFOs noted their direct training experience was focused on financial optimization within the organization.

107

Table 2 (Continued)

Rate training as a priority	All CFOs rated training as a score of 4, as a priority for achieving strategic priorities.	The majority of CFOs (3) rated training as a score of 4, as a priority for achieving strategic priorities.	Seven CFOs rated training as a score of 4, as a priority for achieving strategic priorities.
Areas of alignment	All CFOs noted that the training is well aligned with the strategic priority of optimizing clinical delivery.	All CFOs reported that the training is well aligned with the strategic priority of optimizing clinical delivery.	All CFOs cited the training is well aligned with the strategic priority of optimizing clinical delivery.
Areas of misalignment	Two of the CFOs felt that all areas within their organizations were well aligned. A third stated, "Not that I am aware of because if we are doing something that is not well aligned, then we need to take a second look at that."	No interview themes emerged from CFO interviews.	No interview themes emerged.
Directives to achieve alignment	All CFOs felt senior managers were first and foremost responsible to communicate particularly the strategic priorities to the directors to ensure that quality training services were available for the team.	Two CFOs felt senior managers were first and foremost responsible to communicate particularly the strategic priorities to all levels of the organization, and two CFOs gave advice to directors to ensure that quality training services were available for the team.	Six CFOs felt senior management were first and foremost responsible to communicate the strategic priorities to directors and their role in achieving organizational goals.
Major obstacles impeding alignment	Two CFOs noted inadequate staffing, and two CFOs cited the lack of a solidified training strategy within the organization.	All CFOs cited loss of productivity, referring to the removal of staff from bedside patient care to attend required training.	No interview themes emerged.

Table 2 (Continued)

Downsizing trend	All CFOs disagreed.	The majority (3) of CFOs disagreed.	Seven of the CFOs disagreed.
Areas of needed performance improvement	All CFOs cited patient experience as the area that employees needed to improve to meet their organizations' mission and strategic priorities.	Two CFOs cited clinical nursing skills and patient experience, and two CFOs stated no improvements needed.	Six CFOs cited various aspects of staff skills pertaining to the patient experience, including relationship building and clinical skills.
Future strategies	"No future strategies" was reported for the development of training by all CFOs.	Two of the CFOs said there was "nothing they could think of." The other two participants gave various examples of future strategy.	Six CFOs reported "no future strategies." One CFO cited electronic health record training, and another CFO noted HCAHPS training.
Budget allocation factors	The labor demand model was used to determine the budget allocation for training by all CFOs.	The majority (3) utilized "run rates" to establish a baseline, followed by analyzing costs of proposed training for the upcoming year to determine the budget allocation.	No interview theme emerged. Five CFOs reported "labor demand model." Three CFOs noted "run rates" and proposed training events.
No evidence of training value	All CFOs agree with the statement "Few training directors have been able to provide senior management with convincing evidence."	All CFOs agreed with the statement "Few training directors have been able to provide senior management with convincing evidence."	All CFOs agreed.
Measurement methods	Three CFOs stated, "None that I can think of."	All CFOs stated, "None that I am aware of."	Seven of the CFOs stated "none."

A structural description was compiled from the thematic subsets (Table 2), from which five common themes emerged regarding CFOs' perspectives about HRD and its alignment with strategic priorities:

1. Training is well aligned to the strategic priority of optimizing clinical delivery in hospitals. Organizational strategic priorities cited were (a) optimize the clinical delivery product and (b) grow market share and patient volumes. No future strategies were reported for improving training alignment to priorities. Nursing and staff performance improvement pertains to optimizing patients' experience, which is integral to achieving the priority to optimize the clinical delivery.

2. CFOs view training as a valuable resource for achieving the strategic priorities within their organizations, rating it a score of 4 out of 5.

3. CFOs feel responsible for communicating strategic priorities to HRD leaders and discussing HRD's role in alignment.

4. CFOs disagree that training budgets are being downsized, instead reporting annual increases. They view the training budget as a minimal expense to the organization.

5. There is agreement that HRD leaders are not measuring or reporting evidence of training's value in improving productivity and profitability. CFOs hold themselves accountable for the lack of priority placed on reporting and implementing measurement metrics for training within their organizations. In addition, many CFOs reported that they had not thought of training as a

resource for achieving strategic priorities, instead viewing the training budget

as a fixed cost and not subject to change based on performance metrics.

Chapter 5: Conclusions, Implications, Recommendations

Chapter 5 is arranged into three sections. The first section, conclusions, provides a discussion of the research questions and emergent themes. The second section, implications, explains how practitioners can put the findings into practice. The third section, recommendations, presents practical applications for the study and future research. The main phenomena under study were hospital CFOs' perceptions of the alignment of training and education with the strategic priorities of their organizations.

The genesis of this study came from the researcher's work-related experience as a director of performance improvement (PI) in a nonprofit healthcare system. During this time, the researcher reported directly to the hospital CFO and observed in this role that her department was continually allocated a large annual budget. Conversely, the director of education regularly reported that her department's budget was being downsized annually and did not receive the monies required to conduct training initiatives. When the researcher asked the CFO why he allocated large dollars to the PI department and downsized the dollars to the education department, his answer was simple, "When the education department demonstrates to me that they contribute to the bottom line of this organization, like the performance improvement department, I will give them the money they request." This motivated the researcher to explore the phenomenon in greater depth to understand whether this was a general perception of hospital CFOs and what HRD leaders can learn from CFOs' perceptions and experiences.

This study was framed by three concepts: performance measurement systems, human capital theory, and strategic planning. Performance measurement system (PMS) is

a process that produces a focused set of objectives, measures, and targets that demonstrate the performance of individuals and organizations. The strength of this approach is that it supports accountability by requiring measurable results (Drucker, 2007). Human capital is the recognition that employees are an essential asset to the growth and development of an organization. Their shared attitudes, skills, and knowledge contribute to organizational performance. Any expenditure in training is viewed as an investment, not as an expense (Stockley, 2004). And finally, strategic planning is an organization's process of determining its direction and making decisions on resource allocation, including equipment, materials, and staff.

Critical understanding of the phenomenon of the alignment of HRD to hospital strategic priorities is multifaceted. The researcher expected to find common themes that provided insight into how CFOs allocated dollars and determined effectiveness of training and education within their organizations. Specifically, the researcher expected to discover the characteristics and factors perceived as effective and valuable in hospital training in the hope that insights from the study could contribute significant information to adult education leaders, helping further advance the study of HRD. Before exploring these insights, it is important to disclose that this study was conceptually based on three assumptions, discussed in the conclusion section.

Conclusions

It was immediately apparent from the first interview that the interviewing process allowed the CFOs to step back and review key aspects of training in their organizations. The act of asking questions and having someone listen intently to their answers allowed a

113

dialogue that helped them engage in reflection on three research questions. The questions are discussed in conjunction with the researcher's assumptions and the emergent themes.

Question 1: From the perspective of the CFO, what is the current priority of training in achieving organizational productivity and profitability? Based on this question, a primary assumption of this study was that CFOs are dissatisfied with training in their hospitals and do not perceive it as valuable for achieving strategic priorities. This was based on existing research that reported that the HRD trend of budget downsizing has continued over the past decade (Sugrue & Rivera, 2005). Additionally, in 2009 the *American Journal of Nursing* reported the results of an online survey looking at the recession's impact on nursing education. Over 61% of the respondents said they had seen "slashes in the training budget" for infection control–related educational programs in the last three quarters. From this literature review and personal experience, the researcher's bias was that the declining HRD budget allocation trend is evidence of executives' growing dissatisfaction with training practices.

In conclusion, three important themes emerged. The first theme, training is highly valuable, rated a 4 or 5 as a priority for meeting strategic priorities. CFOs seemed to believe it is important for employees to understand what they are doing and what management's expectations are of their performance. Most CFOs expressed the thought that employees need more training to be as efficient as possible to grow the business that they are in. They all seemed very committed to the importance of being able to train staff, saying that, otherwise, the organization would not be able to grow, and reported that all the management teams recognize this. The second emergent theme highlights the CFOs' perspective that training budgets are not being downsized, but instead in some cases

expanded annually. With the emphasis on CMS's reducing reimbursement, the CFOs believed that training expenditures will continue to go up as a greater emphasis is put on training. This theme is a significant finding because it is contrary to the researcher's bias and to the HRD literature that consistently reports declining budgets (Sugrue & Rivera, 2005).

The third theme showed that there are many areas within the "optimize clinical delivery" priority where training is an effective resource for achieving organizational goals. Additionally, all of the CFOs cited different examples directly linked to the priority of optimizing clinical delivery, with a specific focus on the experience of the patient. One CFO summarized his perspective:

> I think our safety training is going really well, as I mentioned that is on our scorecard, and we have different colors on the scorecard if we are meeting the objectives the company has put forward to us. Everyone thinks of green as the best color, but we have another level, and we call it the blue level. We are actually at the blue level; we are doing really well with our safety and quality training. All quality measures are doing well. That is your core measures, readmissions rates, and mortality rates. We are doing fabulous on all these standards that have been set for us. I think that training is what is turning that scorecard blue, and that has been our focus at our hospital here for the last two years or so.

Question 2: From the perspective of the CFO, how can training departments better align with achieving organizational strategic priorities? The researcher's second assumption, directly linked to this question, was that hospital HRD leaders are responsible for understanding and aligning with CFOs and other financial and operational

115

members of the senior management team in designing training initiatives intentionally

linked to the strategic priorities within their organizations. The bias is that HRD directors

are not taking the initiative to talk directly with these administrative members about their

goals but instead are working entirely on the clinical side of the organization with

differing objectives. However, on further examination, the major theme that emerged was

the CFOs felt senior managers were first and foremost responsible for communicating the

strategic priorities to the directors. Basically, the CFOs described the top-down approach

to reporting.

On the other hand, the CFOs felt the role of HRD leaders in achieving

organizational goals was through communicating and designing "effective training

strategies." One CFO described the director's role in communication with senior

management by stating:

So there may have been barriers in the past to just too quickly say that we don't

have the money or we can't take that much time for education. Those can be

barriers that can really hold back the education director if they don't know how to

voice those issues and work through them. It is really easy to say they [education

directors] do not have the time or money to do it. But if they looked at those as

questions to be answered rather than barriers, then they can still do a lot of those

things without having a huge impact financially. The real barrier has been just not

knowing really what they had the latitude and the freedom to do and maybe

having so much on their plate that they didn't feel that they could be proactive

with our education.

To add to this, the CFOs confirmed that the education directors report to the chief nursing officers and they have no direct authority over the training initiatives within their organizations, possibly contributing to differences in opinion on what training alignment looks like. This seems to be a bit of a roadblock but critical to success. This disconnect seems to have led to what two CFOs described:

> We have a lot of different objectives and opinions within the administrative realm of our organization. So managing through all those different objectives, you know, the different perspectives that people have, and agreeing and coming up with one solidified training strategy and approach is our biggest training obstacle. I think there is a big disconnect between the type of training that some of our clinical leaders believe and some of the administrative and financial leaders believe. So, there has been a big disconnect historically. The clinical leaders believe in a cookie cutter approach that everybody has to go through, and some of the administrative and financial leaders just don't believe that is a rational way to look at it.

Question 3: From the perspective of the CFO, what are the measures used by CFOs to evaluate productivity and allocate resources to training and development departments and programs, for example, FTE hours, operation, and capital dollars? The third assumption related to this question was that HRD leaders, although responsible for implementing performance measurement systems to validate their effectiveness in meeting organizational goals, are not being held accountable in reporting the contribution of their training initiatives to the performance of the system. The significant theme that emerged, confirming the researcher's assumptions, is that CFOs report "few training

directors have been able to provide senior management with convincing evidence that training expenditures have produced evidence of a performance value for their organization." And a majority stated "none that they were aware of" when asked which measurement methods were utilized to determine training's effectiveness. In addition, they noted that the HRD directors would be responsible for reporting these measurements to senior management.

Conversely, when the CFOs were asked why they thought this was not happening, their answers were indicative of the disconnect that exists between the clinical and operational areas of healthcare organizations. Their most common answer was "I don't know, I guess, because I haven't ever thought about it that way." One CFO articulately stated:

No, they are not really reporting anything to me, probably because I am not asking for it. I mean I am really embarrassed that I don't have a more specific pulse on this. I am thinking I might be missing something here. We know it is important, yet there are so many fires that you put out that I have to say training is fairly low on the priority list, which kind of contradicts what I said earlier about training being really important. When I made that statement I really meant it. I mean an effective rollout of all the things we are doing and making sure all our patients are safe, because our nurses are up to speed on things they need to be.

Another CFO went further in stating, "I, for one, have never thought about how I am going to tie the two things together. But I like the idea of thinking of it that way."

In conclusion, one theme emerged: HRD leaders are not reporting evidence of training's value in improving productivity and profitability. Ultimately, CFOs hold

themselves accountable for the lack of priority placed on reporting and implementing

measurement metrics for training within their organizations. In addition, they do not think

of training as a resource for achieving strategic priorities but instead view the training

budget as a fixed cost and not subject to change based on performance metrics.

Implications

The findings of this study have implications for current and future HRD leaders

and practitioners. The first implication is the opportunity for HRD leaders to learn

performance improvement methods and techniques, and to use their knowledge to

incorporate PI measurements and reporting methods into training initiatives. This

knowledge would guarantee HRD services contribute to the performance of the

organization. A successful HRD initiative would require identifying target metrics (e.g.,

reduce operating costs, improve patient satisfaction) and a structured reporting and

monitoring system to ensure that activities are making a measurable impact on a goal.

Results should be measured not by activity (e.g., enrollments and satisfaction) but by

correct movement of defined metrics.

At a time when preserving their profit margin is critical to continued operation,

the majority of hospitals are applying formal performance improvement methods, such as

Lean Six Sigma and Total Quality Management. Using these techniques, hospitals have

improved clinical outcomes, and patient safety, and have experienced improved

productivity (Betka, 2012).

To take advantage of this opportunity, HRD leaders must develop a working

knowledge of these methodologies. The Lean methodology focuses on eliminating waste

or any part of an existing process that is not value added. Six Sigma focuses on reducing

variation in existing processes or redesigning those processes so there are no defective elements (Betka, 2012).

The two performance improvement methodologies work well together. Lean fosters improvement as the result of an overall organizational approach to eliminating waste, while Six Sigma provides a statistical framework for identifying the root cause of problems. Although originally developed for the manufacturing industry, the techniques are increasingly being used in healthcare. A major part of Lean Six Sigma that could inform HRD is watching work in action. Time spent observing work in real time would inform implementation of performance improvement training initiatives (Betka, 2012). Better understanding of these methods would assist HRD leaders with the design of effective training infrastructures and performance measurement systems that demonstrate their contribution to the organizations' priorities and mission.

The next opportunity for HRD leaders is to proactively teach up in addition to teaching down, in other words, proactively educate the senior management team of the critical need to align training with organizational priorities if they are not already on this page. This approach is based on proactivity—defined as HRD leaders taking action first—not reactivity—defined as waiting for senior management to initiate change. Hirschhom and Gilmore (1992) elaborated on the challenge of teaching up:

> Subordinates face the far more complicated task of adequately informing their superiors and helping them to think clearly and rationally, even as they work to implement their superiors' requests. Paradoxically, being an effective follower often means subordinates have to challenge their superiors. In the new

organization, subordinates must challenge in order to follow—while superiors must listen in order to lead. (p. 104)

Recommendations

Based on the findings of this study and the literature reviewed, recommendations are made for HRD practitioners and for areas of future research. The recommendations for practitioners would benefit their efforts to align HRD services with organizational strategic priorities. The recommendations for research would contribute to the exploration of study findings that are at odds with the literature. The researcher has made four recommendations. The first is based on the researcher's belief that it is vital for HRD leaders to establish a unique, far-reaching vision for training in hospitals. This vision should be based on the understanding that an organization should only invest in training that advances its strategic priorities and helps it to achieve its mission. And finally, the new vision is focused on finding new ways to do new things and is not just concerned with fixing problems, but rather with producing growth.

The second recommendation is for HRD practitioners to study and incorporate performance improvement methods into their training infrastructures. Once measurements are implemented, they should schedule ongoing reporting including reporting to senior management, directors, and staff.

The third recommendation is for HRD practitioners to build relationships with the senior management team within their organizations, including the COO and CFO. They should explore opportunities to discuss their organization's strategic priorities and the executives' views of training's value within their organizations, and how it can be improved.

The fourth recommendation is for academic institutions with adult education programs to incorporate additional applied curricula focused on strategic planning models, performance improvement techniques, and performance measurement systems. The researcher believes that practicing the application of these methods in an academic environment would be beneficial to the development of HRD leaders.

Recommendations for Further Research

Based on the findings of this study, as well as observations, a review of literature, and the personal experience of the researcher, the following recommendations are made for future research:

1. Confirmatory studies employing qualitative methods supporting or disconfirming results;

2. Quantitative analysis and qualitative perspectives of training budget trends; and

3. Comparative studies of training alignment with organizational priorities.

Summary

The purpose of this study was to gain understanding of how HRD can align more closely with the healthcare system's strategic priorities from the perspective of CFOs. CFOs were intentionally selected as the focus because they are the drivers of education department budgets and therefore have the authority to determine the viability of HRD within the organization. The researcher hopes that the knowledge gained could potentially contribute to the understanding of what steps need to be taken to ensure HRD's critical place in the healthcare organization and, ultimately, that the outcome of this study could position HRD as a significant contributor to the strategic priorities of

healthcare organizations. Upon completion of this study, further investigation is

suggested to understand HRD characteristics that are viewed by senior management as

effective to achieving organizational goals.

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Appendix A: CFO Job Description

The following CFO's job description was found online at

http://www.accountingtools.com/job-description-cfo:

The chief financial officer position is accountable for the administrative, financial,

and risk management operations of the company, to include the development of a

financial and operational strategy, metrics tied to that strategy, and the ongoing

development and monitoring of control systems designed to preserve company assets and

report accurate financial results. Principal accountabilities are:

Planning

1. Assist in formulating the company's future direction and supporting tactical

initiatives

2. Monitor and direct the implementation of strategic business plans

3. Develop financial and tax strategies

4. Manage the capital request and budgeting processes

5. Develop performance measures that support the company's strategic direction

Operations

1. Participate in key decisions as a member of the executive management team

2. Maintain in-depth relations with all members of the management team

3. Manage the accounting, human resources, investor relations, legal, tax, and

treasury departments

4. Oversee the financial operations of subsidiary companies and foreign operations

5. Manage any third parties to which functions have been outsourced

6. Oversee the company's transaction processing systems

7. Implement operational best practices

8. Oversee employee benefit plans, with particular emphasis on maximizing a cost-effective benefits package

9. Supervise acquisition due diligence and negotiate acquisitions

Financial Information

1. Oversee the issuance of financial information

2. Report financial results to the board of directors

Risk Management

1. Understand and mitigate key elements of the company's risk profile

2. Monitor all open legal issues involving the company and legal issues affecting the industry

3. Construct and monitor reliable control systems

4. Maintain appropriate insurance coverage

5. Ensure that the company complies with all legal and regulatory requirements

6. Ensure that record keeping meets the requirements of auditors and government agencies

7. Report risk issues to the audit committee of the board of directors

8. Maintain relations with external auditors and investigate their findings and recommendations

Funding

1. Monitor cash balances and cash forecasts

2. Arrange for debt and equity financing

3. Invest funds

4. Invest pension funds

Desired Qualifications: The candidate chief financial officer should have a master's degree in accounting or business administration, or equivalent business experience and 10+ years of progressively responsible experience for a major company or division of a large corporation. Should have experience in partnering with an executive team, and have a high level of written and oral communication skills. Preference will be given to candidates with an MBA in Finance and the Certified Public Accountant or Certified Management Accountant designations.

Appendix B: Informed Consent to Participate in Research

Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in research studies. This form tells you about this research study.

We are asking you to take part in a research study called: **ALIGNING HUMAN RESOURCE DEVELOPMENT (HRD) WITH THE STRATEGIC PRIORITIES OF THE HEALTHCARE ORGANIZATION: THE CFO PERSPECTIVE.**

The person who is in charge of this research study is **Carla Breedlove Smith**. This person is called the Principal Investigator. She is a doctoral candidate at the University of South Florida, and is being guided in this research by her faculty advisor, Rosemary Closson, Ph.D.

The person explaining the research to you may be someone other than the Principal Investigator.

The research will be done via conference call at your convenience.

The purpose of this study is to understand the hospital chief financial officer (CFO) perspectives regarding how education and training initiatives can better align with the strategic priorities and deliver significant value to the productivity of their healthcare organizations.

Why Are You Being Asked to Take Part?
We are asking you to take part in this study because you are a CFO employed by Arrowhead Hospital, whose unique experience with hospital productivity and profitability can significantly inform the development of training services that are better aligned with the strategic priorities of your hospital.

Study Procedures
If you participate in this study, you will be asked to:
- Take part in an audiotaped interview via conference call (approximately 35–45 minutes)
- Review the transcript for accuracy, sign it, and return a signed copy to the Principle Investigator.

There is no preparation necessary.

Alternatives
You have the alternative to choose not to participate in this research study.

Benefits
We are unsure if you will receive any benefits by taking part in this research study.
Risks or Discomfort
This research is considered to be minimal risk. That means that the risks associated with this study are the same as what you face every day. There are no known additional risks to those who take part in this study.
Compensation
We will not pay you for the time you volunteer while being in this study.
Confidentiality
All information collected from this interview will be kept as confidential as possible, no names will be disclosed. However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

The Principal Investigator and key personnel.

Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.

The USF Institutional Review Board (IRB) and its related staff who have oversight responsibilities for this study: USF Office of Research and Innovation, USF Division of Research Integrity and Compliance, Department of Health and Human Services (DHHS), and the Office for Human Research Protection (OHRP) are agencies who oversee this research.

We may publish what we learn from this study. If we do, we will not include your name. We will not publish anything that would let people know who you (or your organization) are.
Voluntary Participation/Withdrawal
You should only take part in this study if you want to volunteer. You should not feel that there is any pressure to take part in the study. You are free to participate in this research or withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive if you stop taking part in this study.
Questions, Concerns, or Complaints
If you have any questions, concerns, or complaints about this study, call Carla Breedlove Smith… .

If you have questions about your rights, general questions, complaints, or issues as a person taking part in this study, call the USF IRB at (813) 974-5638.

Consent to Take Part in Research
It is up to you to decide whether you want to take part in this study. This consent form is being provided to ensure you have been informed of the purpose of the study. By signing this form you are indicating that:
- you have read this form and have had it explained to you
- you have had an opportunity to ask questions of the person in charge of this research

- you understand the benefits and risks
- you agree to take part in our research and have been given a signed copy that is yours to keep

Signature of Person Taking Part in Study   Date

Printed Name of Person Taking Part in Study

Signature of Person Obtaining Informed Consent   Date

Printed Name of Person Obtaining Informed Consent

Appendix C: Categories/Keywords

Categories/master codes	Keywords
Budget factors	Turnover rate
	Run rates
Director directives	Agree
Director reporting	Agree
Downsizing trends	Agree
	Disagree
Future strategies	No future strategies
	Patient experience
Major obstacles	Adequate staffing
	Balancing budget
	Disconnected from priorities
Measurement methods	Do not have any
Not aligned	All areas aligned
	Nursing training
	Patient experience
	Other clinical areas
	Volume growth
Performance improvement	Does not know
	Patient experience
	Nurse clinical skills
Priority of training	Rate score of 5
	Rate score of 4
Strategic priorities	Improve clinical delivery product
	Make organization profitable
	Grow market
Training aligned	Clinical nursing delivery product
Training experience	Financial optimization