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HUMAN RESOURCE MANAGEMENT ISSUES IN HEALTHCARE TECHNOLOGY

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ABSTRACT

The purpose of this project is to identify the human resource management issues that are critical to healthcare organizations and to suggest potential responses. Based on case observations, a focus group discussion, and structured interviews with healthcare managers, technology emerges as a major current issue. In what ways will technology impact required personnel? How does technology change the work process? Which new computer skills are required by the changes in technology?

This report presents three related studies used to explore technology and other human resource management issues in healthcare. First, observations were made about how nursing and pharmacist shortages are being addressed by using new technology and by shifting tasks to less qualified staff. Second, a focus group of healthcare managers discussed technology, computer skills, and future projects with a school of business. Third, MBA students using a structured questionnaire interviewed managers from twelve healthcare organizations.

Recommendations as to how schools of business can partner with healthcare organizations include defining and addressing required computer skills, designing programs to develop leaders, creating advanced internship projects, analyzing other industries and comparing them to healthcare, scanning internal and external environments, and exploring new healthcare business opportunities.

INTRODUCTION

As with many other industries, healthcare exists within a brave new world. Therefore, healthcare organizations are facing pressures to change from many sources. Due to universal revisions in management practices and evolution of the values and beliefs about healthcare held by society, healthcare organizations are faced with technology and financial pressures as major drivers of change (McConnell, 2000). In the last decade, healthcare organizations have encountered issues such as decreased reimbursement, shifting of services from the inpatient to the outpatient setting, restructuring through mergers and acquisitions, regionalization and downsizing of personnel to reduce operating costs. At the same time, consumers have come to demand higher quality services, more information about healthcare treatment options and more accountability for performance. Therefore, healthcare organizations must constantly balance the need for cost containment with the need for quality improvement (Leatt and Porter, 2004).

This project explores HR issues in healthcare using three data gathering methods. The project began with job analysis (observing the work process) in one community hospital and one retail pharmacy. Second, the researchers formed a focus group of middle managers from a hospital, a physician practice, a long-term care facility, and a hospice (as a representative of home care services). The agenda for the discussion included: How does technology change the work process?

What are the new skills required by the changes in technology? In what ways can a school of business work with healthcare organizations to address these issues? Third, structured interviews with twelve middle and upper managers from regional hospitals, nursing homes and home health organizations were conducted by MBA students. Seven interview questions were used to gather information on issues and problems healthcare organizations currently face; the pressures that such organizations experience in managing and controlling costs; how these pressures are affecting human resource policies and activities; how technology is changing jobs and hiring practices; and essential skills that are missing among the current workforce.

These three research methods reveal an array of events occurring in healthcare organizations made known through personal reports by managers in their own organizations and through follow-up questions by the researchers. The combined efforts provide rich information for isolating trends and making several remedial recommendations.

OBSERVING CHANGES IN THE WORK PROCESS

A retail pharmacy and a community hospital provide a starting point to consider emerging HR issues in healthcare. These two cases introduce potential solutions to the sometimes-overwhelming shortages of licensed nurses and pharmacists. The solution to staff shortages suggested in these two cases is the shift of tasks from registered nurses and pharmacists to lower paid, unlicensed aides and technicians. One possible outcome of this intervention is that the pharmacist and nurse (and other licensed professionals in like manner) of the future will be more like a foreman than a direct care provider in that he/she will be the coordinator of a work team of varied healthcare technicians.

A pharmacy has installed a state-of-the-art computer system whereby technicians (not the pharmacists) enter all the patient, insurance, and prescription information. A robot fills the prescription (puts pills in the bottle and labels it). A stand alone computer provides quick access to reference information. Ideally, the pharmacist is stationed in the task process to efficiently review the potentially dangerous medicine interactions and to validate the accuracy of work by both the robot and technician. This shift in tasks requires an increase in the level of skills (technical, reading, mathematical, analytical thinking) for technicians. It also requires new mentoring, delegation, assessment and coaching skills on the part of the pharmacist. In this particular case, the installation of the new computer system required an increase in the number of staff and slowed the process of filling prescriptions. One outcome of the case analysis is the realization by the pharmacists that the minimum educational requirement for technicians will need to move to a two-year college degree from the current requirement of a high school diploma to accommodate the needed math, reading and analytical skills associated with using the new system. The other alternative is a longer and more complex orientation program and on-going training for technicians.

In a second case example, a community hospital created a nurse partner program called “Patient Care Teaming”. This program provides three weeks of training and a twelve-week internship to nurse assistants who partner one-to-one with selected registered nurses. The ultimate goal of this partnering is an increase in the registered nurse’s patient load. The nurse and the partner ideally work the same schedule with the nurse assigning tasks, closely observing the partner’s work and documenting tasks performed by both. Two registered nurses in this program were interviewed during the case observation and reported that trusting the partner is key to success of the program. They reported that the most notable outcome of the program is a decrease in work stress resulting from having a trusted person to share both the work and conversation.

As can be seen from these examples, healthcare professionals often now wear two hats, clinical specialist and manager. They must stay abreast of technological changes in their clinical fields as well as perform the role of manager. However, most healthcare managers identify more closely with their specialty than with being a manager according to McConnell (2000). Just as it

is impossible to be a good physician without knowing medicine, a person can not be a good manager without knowing what management is all about (The care crisis, 1991).

FOCUS GROUP FINDINGS

The focus group consisted of four middle and upper level managers representing a large specialty physician practice, a long-term care facility, a hospice, and a regional hospital. While all agreed that the use of technology will increase in healthcare and that jobs will change as a result, they also raised the importance of leadership being able to adjust to these expected changes. There was consensus that good leadership creates a workplace that experiences fewer retention issues and staff shortages.

In terms of the influence of technology on existing jobs, the group reported several specific examples. One, using a computer in the exam room, a physician creates a prescription during the visit and it is waiting at desk to be placed with an appointment card and any clinical instructions or sample medications as the patient goes through the 'check-out' process. Two, using voice recognition software, the physician can capture clinical information while talking with a patient during a clinical visit.

Addressing the skills issue, the focus group members were in agreement that technology increases/changes the required job skills. They also agreed that everyone needs training and development of new technical skills ranging from simple keyboarding and email to analyzing data from telemedicine devices (remote camera and monitoring tools) in the homes of patients. However, participation in such training is low due to the tendency to always be operating in a crisis management mode.

The focus group members were asked to review a list of potential joint projects in which a school of business could work with their organizations. The group was in consensus that leadership training was of strongest interest (e.g., assisting the board of directors in understanding their accountabilities and developing listening skills to really 'hear' the line employees). Internship projects to search literature and construct business plans ranked second followed by industry analysis with the goal of taking successful practices from other industries and applying them to healthcare.

STRUCTURED INTERVIEWS

Twelve middle and upper managers from regional hospitals, nursing homes, hospice, and home care organizations were interviewed by MBA students using seven structured questions. The content from these field reports are summarized.

1. What are the issues and problems that your organization is currently focusing on? The nursing shortage is the most frequently mentioned issue followed by reduced reimbursement rates, the effort required to meet accreditation agency standards and reducing medical errors.

2. What are the pressures that your organization is experiencing to manage and control costs? How are you responding? Has that affected your human resource policies and activities? Responses included a range of cost-cutting ideas such as contracting to reduce the cost of medicines, outsourcing to contractors, reducing the use of temporary agencies, self-funding employee health insurance, freezing overtime, and offering non-cash benefits.

3. How has technology changed jobs in your organization? What are some of the changes in providing for patient care? Interviewees report several examples including use of laptop computers by nurses and new technology to monitor patients at home reducing the need for a nurse to make a

home visit. One benefit of technology is more readily available reference material, which provides real time guidance in care planning. One organization predicts that a doctor will soon be able to treat patients who are unable to leave their home just by evaluating them through a video camera and other in-home devices.

Four out of the twelve organizations report staff reductions (e.g., clerical) due to technology and no organization reports increases in staff (contrary to the observation case in the pharmacy reported earlier). Four organizations report anticipation of decreased costs and four organizations report increases in costs due to technology. There were several comments that technology is expected to improve quality and patient care though no measurement indicators were offered. Several organizations note the large upfront investment that technology requires as a negative incentive to move into the technology age.

4. What new jobs have been created? Are jobs changing? Has your organization recently written job descriptions? Three organizations report annual evaluation of job descriptions. One hospital meets twice a year to review job descriptions. A home care agency reports recently revising job descriptions for visiting nurses. A long-term care facility just added new jobs descriptions for a wellness program.

5. In hiring, where is your organization experiencing shortages? How do you manage recruitment in these shortage areas? On the topics of staff shortages and hiring practices, it seems that each organization has settled into routines on how they handle the nursing shortage. A hospice uses direct mail to a list of nurses in the region. This is followed up with an open house; four nurses have recently been hired. They call this program 'extra effort recruiting' and consider the program successful. One organization has returned to using only word-of-mouth to make available openings known to established contacts in the community. The interviewee reports the process is working well and is less expensive. Contrary to the typical nursing shortage scenario, a government healthcare organization interviewee reports that 30 nurses recently applied for an open position and the organization was able to hire its first choice. A home care organization interviewee specifically mentioned a problem with recruiting nurse assistants in that these persons are drawn from the same labor pool as retail and restaurant workers. She surmises that many within the pool do not wish to provide the intimate personal care required in home care nursing.

6. What skills do your employees (and applicants) not have that you wish they had? Three interviewees listed more computer skills for nurses. Others noted a need for basic communication skills, a better work ethic, and more maturity.

7. What else can you tell me about human resources management in the healthcare setting? What are some of the HR issues that you deal with week to week? Compensation issues (defined as the need to reevaluate jobs and adjust hourly pay rates) were mentioned by three interviewees. Other issues include absenteeism, how to manage a poor performer, scheduling methods, and overtime.

CONCLUSION

Based on the case studies, the focus group, and the interviews, future studies are suggested. Possible recommendations as to how schools of business can partner with healthcare organizations include defining and addressing required computer skills, designing programs to develop leaders, creating advanced internship projects, analyzing other industries and comparing them to healthcare, scanning internal and external environments, and exploring new healthcare business opportunities.

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CONSUMER DRIVEN HEALTHCARE, THE LATEST PRODUCT DESIGN IN THE U.S.

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ABSTRACT

Healthcare, in the United States, continues to grow faster than workers' income without any signs of slowing down. Employers are desperately seeking shelter from the annual double digit increases in healthcare and the government is looking for ways to improve the delivery system in the hopes of controlling what can only be compared to as a run-a-way train. The latest plan design to gain popularity in the United States is consumer driven healthcare (CDHC), a term coined by Harvard professor and leading industry expert, Dr. Regina Herzlinger. Many employers view consumerism as a solution to the cost issue. Consumer driven healthcare is based on a market-oriented strategy which encourages consumers to actively participate in the procurement of healthcare services, while creating savings vehicles that can be utilized to pay for that care. CDHP plans allocate a set sum of healthcare dollars and give their members the freedom to make their own healthcare decisions. President Bush strongly supports CDHC as it is congruent with his belief that individuals should assume more ownership in benefits. Many consumers already find themselves allocating significant portions of their incomes to pay for healthcare. This predicament coupled with the plethora of direct advertising to consumers, leaves advocates of CDHC, spouting its virtue. However, CDHC is not without its critics. Those questioning the benefits of CDHC suggest that it is merely a cost-shifting plan which does little to control costs. Moreover, the incentives inherent in the plan design may foster patient behavior that is the antithesis of what is expected. The purpose of this paper is to explore the concept of CDHC and analyze its viability in the American healthcare system.

WHEN THE FORCES OF INDUSTRY CONFLICT WITH THE PUBLIC HEALTH: THE CASE OF OBESITY

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ABSTRACT

When the growth and prosperity of an industry, or industries, depend upon perpetuating a preventable human infirmity, what are the incentives to enlighten the public and thereby change the pathology of that infirmity? None, according to this pessimistic case addressing one of the most prevalent disabilities in America: obesity. While the "business" of obesity is the central theme of this article, the discussion mirrors a similar conundrum throughout the healing industries – and it raises a troubling ethical dilemma. As with obesity, major industries have grown up around virtually every common human ailment, and to insure growth in these business sectors those ailments are conveyed as normal, predictable, and unavoidable – with relief available for purchase in the drugstore, in the bookstore, or on the operating table.

This article presents a compelling case for why the public suffers, and will continue to suffer, from an epidemic of obesity. It also shows how the natural forces of capitalism work inexorably to keep the public naive to the pathology of obesity, and reinforce a perspective of normalcy toward an infirmity that dramatically curtails lifestyles and foreshortens lives.

HEALTH CARE COST OF DIABETES DUE TO ACCULTURATION RELATED OBESITY IN NON-TRADITIONAL LATINO IMMIGRATION LOCATIONS

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ABSTRACT

The Latino population is the fastest growing minority group in the US. Due to language barriers, documentation and insurance status, much of this newly arrived population is unable to utilize or to afford primary and preventive health care services. As acculturation occurs, rates of many chronic diseases, such as obesity and diabetes, increase. Obesity and diabetes related complications in immigrant populations, without preventive care and early diagnosis, pose a serious financial impact on our health care system. Non-traditional immigration states, such as North Carolina, are experiencing tremendous increases in the Latino population. Limited research documenting insurance status, health care utilization, obesity and diabetes rates has been conducted in these non-traditional immigration sites.

A needs assessment (N=166) was conducted in Guilford County, North Carolina to determine the current health status and needs of Latino immigrants. Respondents are primarily without health insurance, use the health department more often than the emergency room as a primary care facility and have obesity rates higher than national averages. Additionally, Latino community diabetes screening revealed high levels of undiagnosed diabetes. The proportion of respondents reporting the use of the health department as a primary health care source is higher than previously reported rates in similar populations. Insurance status indicates these individuals are unlikely to have access to primary and preventive health care services. Without preventive care, diabetic complications will have an increased financial impact on the health care system. Early prevention efforts targeting both documented and undocumented immigrants in non-traditional immigration areas would be a cost effective approach to lessen future diabetes and obesity related financial health care costs.

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