



# CareerSTAT

**A GUIDE TO MAKING THE CASE FOR INVESTING  
IN THE FRONTLINE HOSPITAL WORKFORCE**

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JOBS FOR THE FUTURE/NATIONAL FUND FOR WORKFORCE SOLUTIONS

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## JOBS FOR THE FUTURE

Jobs for the Future develops, implements, and promotes new education and workforce strategies that help communities, states, and the nation compete in a global economy. In more than 200 communities across 43 states, JFF improves the pathways leading from high school to college to family-sustaining careers.



The National Fund for Workforce Solutions is an award-winning national initiative dedicated to providing skills to low-wage workers necessary to obtain good careers while at the same time ensuring that employers have the high-quality human capital necessary to compete in today's dynamic global economy. The National Fund serves the workforce needs of both workers and employers by organizing close relationships and a deep understanding of a variety of industry sectors in order to ensure that targeted investments are made to create skills that employers truly value and which will lead to career advancement.

## CareerSTAT

CareerSTAT, a project of the National Fund for Workforce Solutions and Jobs for the Future, is an initiative to document and endorse the business case for investing in frontline hospital workers. It is creating a “Guidance Tool for Productive Investments in Frontline Hospital Workers” and establishing an employer-led advocacy council for expanding investments that yield strong skill development and career outcomes for low-wage, frontline hospital workers.

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## EXECUTIVE SUMMARY

The U.S. health care system is at a turning point, and no more so than in the nation's hospitals. They face increasing pressures to provide more and better care at lower cost. At the same time, revenue streams—from Medicare and other sources—are uncertain, as is the future of health insurance reform. New models are emerging for coordinating care and delivering it in a patient-centered way, as are new technologies, from new diagnostic and treatment methods to electronic health records. And the emphasis on demonstrated, measurable evidence of hospital performance has rarely been greater.

Yet one thing is constant: health care is a distinctly high-touch, labor-intensive enterprise. And it depends in part on workers at the front lines of care: nursing assistants, housekeepers, medical assistants, unit secretaries, dietary service workers, and a host of others who work 24/7 to answer call lights, empty bed pans, pass trays, or draw blood. Today, some health care providers are discovering that investing in the education, training, and career advancement of these frontline workers pays off not only in dollars and cents but also in less measurable ways, including enhanced worker performance and skill, better functioning patient care teams, expanded pipelines for filling positions, and improved morale.

The concept of investing in the frontline health care workforce is in good currency, but translating that into wider practice is not simple. At times, it requires overcoming the skepticism of decision makers, both private and public, about the value of long-term investments in human capital. It requires clear models, compelling arguments, and evidence to back them up. But in all cases, it requires engaging the leaders in the “C-Suite”—chief executive officers, operating officers, financial officers, human resources officers, nursing officers—in bringing the case to their peers in other institutions.

This guidebook was prepared for CareerSTAT, an employer-based project to make the case for developing frontline hospital workers. It documents effective practices in leading hospitals around the United States, drawing on interviews with senior managers and executives. It presents the arguments that managers themselves make for investing in the training and education of less-skilled workers, along with the types of evidence and metrics that managers and senior decision makers find most persuasive.

### THE VALUE PROPOSITION: WHY HEALTH CARE PROVIDERS INVEST

Interviews with hospital leaders reveal a wide range of perceived benefits from such investments, falling into four broad categories.

**Addressing Human Resources and Labor Market Challenges:** The labor market is the most common motivator for investing in frontline workforce programs. Compelling needs to fill positions or stem turnover lead hospitals to build “pipelines”—internally, from frontline

to higher-skilled positions, and externally, from the community into entry-level positions. Evidence of program impact includes lower staff turnover and vacancy rates, with reduced costs in recruitment, orientation time, and use of temporary agencies.

**Employee Morale and Motivation:** The impact of improvements in employee morale and motivation are harder to measure than benefits associated with labor market challenges, although they may be identified at least in part through surveys of employee engagement. Program leaders and executives speak of the improved morale associated with workers who become more self-confident or who feel more empowered.

**Performance Improvement:** Performance improvement involves both the skills and capacity of an individual worker to perform his or her job effectively, and the ability of the health care provider to meet performance standards for delivering quality care – its own, as well as external measures. Reimbursements for hospitals from the federal Center for Medicare and Medicaid Services will soon be based, in part, on patient satisfaction, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems.

**Organizational Mission:** Leaders point to the intrinsic value of workforce programs. In this view, investment is driven by a commitment to the staff and the community. Evidence of providing tangible community benefits can be a factor in maintaining nonprofit status, for example. Even for world-class teaching and research organizations, serving the community is core to the mission. Creating a diverse health care workforce—one that reflects the makeup of the community and the patient population—is also critical.

#### MAKE LEARNING ACCESSIBLE TO WORKERS

There is no “one size fits all” model for hospitals to invest in their frontline workforce, but certain features are common:

- Clear pathways and guidance for advancing to higher-skilled roles, both within an employee’s current occupation and in additional fields
- Instruction at the workplace in basic or remedial skills, technical skills, and credit-bearing academic courses leading to a certificate or degree; tutoring
- Intensive coaching and mentoring, cohort-based learning; assistance with interpersonal or “soft skills” and other critical work behaviors
- Supportive human resources policies and practices, including release time for training at work; assessment of education, skill levels, and career interests; extensive orientation; and pre-payment of tuition benefits when enrolling in a course of study

## METRICS MAKE THE INVESTMENT CASE

Hospitals make the case for frontline worker investment in myriad ways, but how do they know that these investments make a difference? Leaders interviewed for this guidebook—as well as the executives they report to—have differing standards of evidence. While few conduct formal return on investment analyses, several point to evidence of impacts on costs and cite measurements to back that up. And one hospital partnership undertook a formal ROI study that produced powerful results: the employer’s return on investment was nearly 12 percent.

Data collection and analysis can take any of several forms:

- **Tracking student progress in training and education**, including retention in programs, course completions, degrees and certificates attained, and career progression;
- **Tracking traditional human resource metrics**, including turnover, vacancies, separations, attendance, and related costs (e.g., overtime pay; costs associated with temporary agencies); and
- **Measuring impacts specific to frontline workforce investments**. Well-designed and carefully chosen metrics can contribute to a bigger payoff from workforce investments, by ensuring that programs target specific needs and support a hospital’s strategic direction.

## RECOMMENDATIONS FOR MAKING EFFECTIVE PRACTICE STANDARD PRACTICE

This guidebook is an invitation to hospitals to join a conversation about the potential value of “growing their own” skilled workforces—and building a learning culture to support this effort. In the spirit of furthering this vital conversation and making an effective case for taking good practices to scale, we offer several recommendations:

**Move from “boutique” projects to “business as usual.”** Determine strategies for institutionalizing and scaling up good practices in the development of the frontline workforce.

**Continue gathering intelligence and checking assumptions against practice.** Validate the practices and metrics presented here with other providers and supplement or revise them as necessary.

**Don’t reinvent the wheel.** Adopt and customize existing templates and practices to your own practice. Establish common templates and collection tools for use by other organizations in the region, and share costs as well as data.

**It’s not just about recruitment.** Given the lingering effects of recession, a business case based on labor shortage is less convincing than one grounded in performance upgrading and consumer-centered care.

**Set a high bar.** Establish the practices and metrics used by these hospitals as benchmarks for other providers, health care systems, and state and national associations.

**Create rewards for building better metrics.** Advocate for the creation of a competition and awards (or other recognition) for development and application of business metrics to frontline workforce investment.

**Remember that measuring impact is as much art as science.** The strongest case is usually made with multiple methods, combining “hard” data with textured portraits of individual workers and perceptions of what supports career advancement.

**Foster business-to-business learning.** Establish formal and informal learning networks to stimulate the adoption of good practices and metrics and cultivate champions in additional hospitals.

**Move the policy debate.** Develop advocacy strategies and coalitions to inform federal and state health care workforce policy. Build alliances with the education and workforce communities and among employer, worker, and consumer advocates in linking quality jobs to quality care.



# CAREERSTAT: A GUIDE TO MAKING THE CASE FOR INVESTING IN THE FRONTLINE HOSPITAL WORKFORCE

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The U.S. health care system is at a turning point, and no more so than in the nation's hospitals. They face increasing pressures to provide more and better care at lower cost. At the same time, revenue streams—from Medicare and other sources—are uncertain, as is the future of health insurance reform. New models are emerging for coordinating care and delivering it in a patient-centered way, as are new technologies, from new diagnostic and treatment methods to electronic health records. And the emphasis on demonstrated, measurable evidence of hospital performance has never been greater.

Yet one thing is constant: health care's singular reliance on the human factor. It is a distinctly high-touch, labor-intensive enterprise. And it depends in part on workers at the front lines of care: nursing assistants, housekeepers, medical assistants, unit secretaries, dietary service workers, and a host of others who work 24/7 to answer call lights, empty bed pans, pass trays, or draw blood. This workforce, often invisible to the “consumers” of health care, remains essential to the delivery of quality care.

Some health care providers are discovering that investing in the education, training, and career advancement of frontline workers pays off not only in dollars and cents—for example, when turnover, recruitment, or other costs decrease—but also in less measurable ways: enhanced worker performance and skill; better functioning patient care teams; expanded pipelines for filling positions; and improved morale, among other benefits. And these employers go beyond the standard menu of employee benefits. A growing number of hospitals and other health care providers are building career ladders from less-skilled to higher-skilled jobs, preparing workers with the academic and life skills required for college and careers, and dedicating professional staff and resources to workforce development. Among these institutions are some of the nation's most distinguished teaching and research hospitals, as well as scores of lesser-known community hospitals and clinics, long-term care facilities, and other providers.

The concept of investing in the frontline health care workforce is in good currency, but translating that into wider practice is not simple. At times, it requires overcoming the skepticism of decision makers, both private and public, about the value of long-term investments in human capital. It requires clear models, compelling arguments, and evidence to back them up. But in all cases, it requires engaging the leaders in the “C-Suite”—chief executive officers, operating officers, financial officers, human resources officers, nursing officers—in bringing the case to their peers in other institutions.

This guidebook was prepared for CareerSTAT, an employer-based project to make the case for developing frontline hospital workers. It documents effective practices in leading hospitals around the United States, drawing on interviews with senior managers and executives. It presents the arguments that managers themselves make for investing in the training and education of less-skilled workers, along with the types of evidence and metrics that managers and senior decision makers find most persuasive. This evidence extends to formal methods of making a business case for investments, including return on investment analyses, and, more commonly, to evidence grounded in solving common business problems (e.g., reducing turnover; increasing customer satisfaction; avoiding errors; filling critical vacancies). It provides concrete examples of hospitals, both singly and in partnerships, that are making these investments and making the case for them in today's challenging environment.

As this guidebook demonstrates, there is a wealth of practical models for building a productive frontline workforce and advancing these workers into higher-skilled roles. But while a substantial number of health care leaders are applying these models, they remain the exception. This is in part because of a deeply ingrained focus in medicine on the preparation of the highest-skilled professionals—physicians, nurses, and other licensed and highly educated practitioners. It is also a function of low margins and high cost pressures on health care providers.

That said, the limited investments in developing workers on the frontlines also stem from a lack of knowledge about leading efforts in this realm and the value they add to health care delivery. CareerSTAT is a focused effort to capture and disseminate key lessons and models from this work. Hospital leaders in CareerSTAT, with the assistance of Jobs for the Future and the National Fund for Workforce Solutions, guided the development of this report; they will employ it to promote the wide adoption of effective practices.

# EFFECTIVE INVESTMENTS IN FRONTLINE WORKFORCE DEVELOPMENT

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## MAKE LEARNING ACCESSIBLE TO WORKERS

There is no “one size fits all” model for hospitals to invest in their frontline workforce, but certain features are widespread. The most fundamental is the concept of making the workplace “learning friendly” for full-time workers who come with all levels of prior education. Common features of these learning-friendly health care providers include:

- Clear pathways and guidance for advancing to higher-skilled roles, both within an employee’s current occupation and in additional fields;
- Instruction at the workplace in basic or remedial skills, technical skills, and credit-bearing academic courses leading to a certificate or degree;
- Intensive coaching, mentoring, case management (including referral to supporting services such as child care, transportation, or other needs), cohort-based learning, tutoring; and
- Supportive human resources policies and practices, including release time for training at work; the systematic assessment of education, skill levels, and career interests; extensive and structured orientation programs; and payment of tuition benefits when enrolling in a course of study.

*See Appendix I for good practices in frontline worker development.*

At Boston’s Beth Israel Deaconess Medical Center, being a “teaching hospital” has traditionally meant teaching doctors to deliver world-class care as well as research. As the hospital has grown to embrace frontline workforce development, it has extended the “teaching” ethos to all levels, from housekeepers and lab technicians to senior clinicians. The latter may volunteer as tutors to the former in college math or biology courses taken at the hospital. An evaluation of BIDMC’s comprehensive workforce approach found that at least 10 percent of the hospital’s staff has been touched by its frontline initiatives (Hebert 2011).

For learning-friendly institutions, not only does the learning extend to all but all are also expected to support the learning process. Supervisors or higher-level staff serve as coaches or mentors to workers in training. Workers receive release time to attend courses. In some cases, supervisors are evaluated in part based on the advancement of those in their charge. At Children’s Hospital Boston and Rhode Island’s Women and Infants Hospital, workers receive tuition support when tuition is due rather than wait to be reimbursed later, facilitating enrollment. University of Colorado Hospital is also an innovator in tuition support, offering a loan forgiveness program.

### MAKING EDUCATION ATTAINABLE: UNIVERSITY OF COLORADO HOSPITAL

For almost a decade, University of Colorado Hospital has supplemented its tuition reimbursement program with a unique innovation—one that has proven popular with its workforce. As an investment in its employees, the hospital loans up to \$7,000 per year for two years (up to \$14,000) for any staff member enrolled in work-enhancing training and education. The hospital loaned \$150,000 in 2011 at an average level of \$5,000 for each of the 30 workers taking advantage of the benefit.

The worker has the option of repaying the loan in hours of work, with a credit of \$2 for each hour of work during the loan period, and the hospital has no requirement for how the loan will be used. Any employee who is enrolled in an approved program may use it for anything that connects to succeeding as a student. The loan usually covers tuition and fees beyond those covered by standard reimbursement policies. However, it can also be used for such practical needs as child care to free more time to take classes, living expenses for working fewer hours while studying, or buying a car to get to work, home, and school more efficiently.

Enrollment need not be in a degree-granting program, and online courses are popular for work-constrained students. Many employees have used the loan to take CNA, medical assistant, and higher-level nursing and technician training, and the hospital encourages applications to gain IT-related training.

### COACHING FRONTLINE WORKERS: BALTIMORE ALLIANCE FOR CAREERS IN HEALTHCARE

For the Baltimore Alliance for Careers in Healthcare—BACH—the role of the coach in workforce programs is pivotal to the growth of individuals and to the creation of a learning culture in a hospital supporting that growth. Coaches—sometimes drawn from the ranks of nurses and supervisors, in other cases hired externally—foster career growth by advising workers on educational options and assessing their interests and abilities. Equally important, the coaches mentor individuals in doing their current jobs better. Where necessary, coaches may refer workers to Employee Assistance Programs for assistance with balancing work and family pressures, or to staff designated as “navigators” to help them find resources such as child care, transportation, or even emergency funds to buy groceries. First and foremost, coaches work with frontline workers to remove barriers and support their advancement.

While BACH-affiliated hospitals use a variety of methods and arrangements for coaching employees, their coaches all seek to be “facilitators.” In this role, the coach mainly asks questions and challenges employees to find answers from within themselves based on their unique values, preferences, and perspective. This is critical for mastering the core behavioral competencies, or “soft skills,” that assist in retention and career advancement in frontline and higher-skilled positions.

The coaching role and job description varies among the hospital partners in BACH. Some, including Johns Hopkins Bay View and Sinai Hospital, employ full-time, dedicated coaches, while others, such as Good Samaritan, embed coaching in the responsibilities of selected nurse-supervisors. Some focus on mentoring candidates for nursing degrees, while others focus on advising the hospital’s first ranks, in environmental services, dietary, and similar areas, about education, job success, and career paths.

*“The coaching and career mapping elements of our work with BACH were ‘keys to success.’ The career map helped workers see a future for themselves, and the coaching was valuable in giving supervisors someone to talk to before a problem with the new worker starts.”*— JoAnn Williams, University of Maryland Medical Center, a BACH-affiliated hospital

Tuition advancement, as at University of Colorado Hospital, and the extensive use of employee coaching, as at hospitals in Baltimore and Boston, for example, illustrate the comprehensive approach to supporting employee learning while working. But the support, as employers and their partners have found, does not end with the working day. Nor does it begin on the first day of the job. Successful frontline worker initiatives address barriers to job performance as well as career advancement. Such barriers can be behavioral. Employees with poor attendance, work habits, or interpersonal skills are common concerns for managers interviewed for this guidebook. Frequently, the experience of living with poverty, or incomes close to the poverty line, underlie these problems. An absent or low-performing employee may be juggling a child's illness with the need to earn enough to cover a missed payment for rent.

Removing such barriers to success at the hospital takes a two-pronged approach: working directly with employees to build confidence and address problems, while working with their supervisors and managers to understand the life situation of the working poor and its implications for the workplace.

Hartford Hospital employs “YES” (Your Educational Success), an on-the-job program that serves as a bridge to success in college. Participants learn to develop goals, improve time management and interpersonal skills, while identifying barriers to success. At the same time, students enhance their grammar, math, and other foundational skills critical to academic and job advancement.

Hospitals in Fort Collins, Colorado; Erie, Pennsylvania; Youngstown, Ohio; and Louisville, Kentucky, all report success with programs to train managers about the barriers imposed by low incomes. Notable models include the “Walk a Mile Experience,” a poverty simulation designed by United Way of Massachusetts Bay, and “Bridges Out of Poverty,” used successfully by Ohio's Humility of Mary Health Partners. Employers report that tools such as coaching, courses in “core behavioral competencies” (work norms, interpersonal skills), and poverty simulations, have markedly improved retention—in training and educational programs and in the job itself. Chicago's Saint Anthony Hospital attests to the powerful combination of education on the job with “wraparound supports” (see *box on page 6*).

These employers have forged strong partnerships with local organizations and agencies in support of staff education and advancement—with community and technical colleges, community-based organizations, public workforce organizations, public/private funding collaboratives, and unions, including labor/management training funds. Such bonds enable education that is “worker friendly.” Incumbent workers may attend college or precollege courses at the workplace, with college faculty or employer staff members serving as adjunct instructors. Education and workforce partners gain a deeper understanding of employers' skill needs and craft more responsive programming. As Michael Paruta of Providence, Rhode Island's Women and Infants Hospital notes, a partnership with Genesis Center, Dorcas Place, and other leading CBOs made it possible to inform community groups and residents about the hospitals' workplace standards, while offering employers a template for training lower-skilled community residents and current health care staff members in basic and job-related

skills. Other community partners have played equally significant roles in areas such as recruiting, screening, training, and supporting the retention of frontline workers.

#### LINKING LEARNING WITH LIFE AND WORK SUPPORTS: SAINT ANTHONY HOSPITAL

Saint Anthony invested in its frontline workers by implementing “School at Work,” a model that combines mentoring, coaching, and life management skills with online health care coursework. To augment SAW, the hospital collaborates with the City Colleges of Chicago and community-based organizations to address issues impeding their frontline workers from achieving further education and advancement in health care. Since it started in 2009, every employee who participated in the program has completed it and enrolled in college. Employees also received full mentorship support from the hospital’s senior and management staff. As a result, several employees have advanced in their careers at Saint Anthony.

*“Providing support services such as career advisement, mentorship, child care assistance, housing subsidies, and financial literacy workshops was an integral part of the program success.”—Pamela Jones, Human Resources and Director of Workforce Development*

### ADAPT TO SHIFTING NEEDS AND OPPORTUNITIES

Another shared feature among the hospitals contributing their experience for CareerSTAT is the evolution of effective workforce efforts. None of these has come into full-blown existence overnight, however. Typically, they begin as pilots focused on a single issue (e.g., a shortage of radiologic technologists; limited facility with English or other basic skills among entry-level staff). The efforts expand as new needs emerge (e.g., meeting higher performance standards in central processing; filling vacancies in nursing; monitoring technicians). As the benefits of the initial effort become apparent, the hospital or the larger partnership invests more broadly in a continuum of career advancement programs.

Children’s Hospital Boston and its community-based partner, JVS, created such a continuum, “Bridge to College,” after initial success with ESL and other foundational instruction provided by JVS. The hospital’s workforce director, Karen Schoch, summarizes this work as “putting the resources in place to meet students where they are.” Similarly, Boston’s Beth Israel Deaconess Medical Center filled a vital gap between entry-level training programs and college-level pipelines with the “Employee Career Initiative,” which incorporates counseling, tutoring, and free, on-site precollege and college-level “gateway” courses in the sciences.

Flexible, sustainable workforce initiatives create tools and routines that can be employed readily as templates when demands shift or hospital strategies change. These templates include curricula, manuals, instructional models, train-the-trainer modules for coaches, staffing and scheduling policies, and arrangements with education providers, among others. For example, demand for new unit clerks subsided for hospitals in Jackson, Mississippi, and Youngstown, Ohio. Program leaders in both cases shifted their emphasis almost seamlessly to programs for training staff to advance to become nursing assistants or fill equivalent roles.

## LEVERAGE EXTERNAL AND INTERNAL INVESTMENTS

Another touchstone among leading programs has been seed capital provided by public and philanthropic investment. In the late 1990s, hospitals in Cincinnati (UC Health and Children’s Hospital) and Boston (Children’s Hospital and others in the city’s Longwood Medical Area) initiated pipeline programs targeting low-income community residents. Others received initial support from the U.S. Department of Labor, community foundations, or the Annie E. Casey Foundation, the Charles Stuart Mott Foundation, and other national philanthropies. In such cases, modest start-up grants provided “an incentive for people to meet together,” according to Bill Lecher of Cincinnati’s Health Careers Collaborative. Small pilots built credibility for more extensive pathway programs, as well as interest among partners and funders and in the hospitals. Yvonne Myers of Colorado’s Columbine Health System, a long-term care provider, explains that for garnering grants, “it is critical to have a group that has been working together. The grants often rally groups together to start, but then they stay together if the group has value in itself.”

### STRATEGIC USE OF GRANT RESOURCES: COLUMBINE HEALTH SYSTEM

For Columbine Health Systems in Colorado, funding from the Health Resources and Services Administration, the American Recovery and Reinvestment Act, and the Center for Nursing Excellence (the region’s National Fund for Workforce Solutions collaborative) have made scholarships and other benefits possible while leveraging the provider’s operational funds.

*“Our CEO supports this, and the CFO likes that others invest in the work to leverage our own money. For example, even though the program cost \$80,000, the grant for \$23,000 makes us feel we are supported and our investments are good ones.”—Yvonne Myers, Director of Human Resources, Columbine Health Systems in Colorado*

Outside support has enabled hospitals to invest in their workforces more intensively—providing a deeper level of services and career opportunities—and more extensively—expanding the number and types of employees and occupations supported. In some cases, pooled funding by local grantmakers has fostered both intensive and extensive growth in workforce investment and leveraged greater commitment of operating funds and in-kind investment from employers. This has been most evident in regions with mature health care partnerships—Boston, Cincinnati, Baltimore, Denver, and Providence. Large, multi-hospital consortiums (e.g., Boston’s Healthcare Training Institute, Cincinnati’s Health Careers Collaborative, the Baltimore Alliance for Careers in Healthcare) have achieved significant scale and sustainability in terms of duration, numbers of workers and employers served, and in building models for other partnerships to emulate.

Critical to the success of these partnerships—and to the workforce initiatives in their member institutions—are “intermediary organizations” that host, manage, and serve as the infrastructure or glue for partnerships of often-competing employers. These entities, typically nonprofit organizations, convene employer and educational partners, assemble private and

public resources, and develop or broker workforce programs and support services. Some also provide direct services, including clinical and academic instruction. They take varied forms:

- Boston’s Healthcare Training Institute is the initiative of a community-based organization, JVS, that incubated a number of successful program models, including “Bridges to College,” spanning Children’s Hospital Boston and six other HTI partner hospitals, and technical training for central processing (operating room) technicians. It is also one of the city’s major providers of instruction in foundational skills, such as literacy and English for Speakers of Other Languages.
- Philadelphia’s Partnership for Direct Care Workers is managed by a joint labor/management partnership, District 1199c Training and Upgrading Fund. The fund, which is also Philadelphia’s largest trainer of the health care workforce, serves both union members and community residents. With its employer and educational partners, it has been an innovator for 34 years in developing work-based and classroom learning from foundational skills to college degree programs in health care.

Hospitals in these partnerships have benefited from new or strengthened contacts with neighboring institutions, sharing information and advice. Partnerships can also bring important economies of scale. Stepping Up Rhode Island discovered that group purchasing arrangements with colleges lower workers’ educational costs. BACH gained leverage in public and professional arenas when it enlisted a key board member to win flexibility from the state’s nursing board in regard to training nurse aides in the hospitals, rather than requiring them to train in nursing homes.

## **ENGAGE LEADERSHIP AND BUILD CAPACITY**

A frequent recommendation coming out of workforce development efforts is to identify executive and mid-level “champions.” This is borne out by every institution contacted for this guidebook, yet it tells only half the story. Champions are not the only drivers of successful frontline worker programs in their institutions; success is nurtured as well by organizational policies, programs, and structures. And such structures have the potential to keep workforce initiatives alive when a champion departs.

Toward this end, some leading hospitals have established dedicated units or positions targeting “workforce development,” as distinct from traditional human resources or staff education departments. Rhode Island’s Women and Infants Hospital, Ohio’s Humility of Mary Health Partners, and Boston’s Partners HealthCare, Children’s Hospital, and Beth Israel Deaconess Medical Center all have specialized workforce director positions, most of whom are funded from operating expenses.

With a dedicated position—particularly with additional staff support, such as hospital-based coaches or tutors—the champion can devote more attention to the elements of program success: assessing needs; building relationships with workers and managers; and adapting

workforce activities to changing labor demands. Such capacity, whether in the form of a dedicated workforce director or in existing staff education units, as in Bradenton, Florida's Blake Medical Center, is critical to keep frontline worker priorities front and center.

Even with a permanent workforce function in place, it is equally vital to enlist the ongoing support of senior leadership and department heads. Blake Medical Center's vice president of human resources, Veronica Lequeux, accents this point. "Very senior management must be included in the dialogue early, and their commitment to the resources are needed up front."

Keeping them engaged is important as well. This means providing not only data points about numbers served and problems solved but also concrete human stories that connect program abstractions to personal success. When Larry Beck was president of Good Samaritan Hospital, he was a receptive audience for such stories by dint of coming up through the ranks himself, beginning as a housekeeper. When executives attend graduation ceremonies and other celebrations, meet candidates, and hear their stories directly, he says, "That's when they get it."

Finally, it is just as essential to enlist support laterally, from a variety of units across a facility. In Tacoma Park, Maryland, Washington Adventist's Beverly Jackson emphasizes the high level of involvement required of human resources staff in order to support people, especially since the programs benefit many units in the facility.

# THE VALUE PROPOSITION: WHY HEALTH CARE PROVIDERS INVEST

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Clearly, some U.S. hospitals are “walking the walk” in terms of supporting the skills and career growth of their frontline workforce. But *why* are they doing it, especially in today’s straitened economic circumstances?

Interviews with hospital leaders reveal a wide range of perceived benefits from such investments. While hospitals frequently start these initiatives to address specific skills shortages, slack labor demand in recent times has not negated the benefits of improved morale, cost reductions, and improvements in patient care and satisfaction. And even for financially minded decision makers, these programs are not solely about the bottom line. As one executive advises, “You’ve got to look at their mission statement.” Hospital representatives also note that so-called intangibles—community service, staff morale—have significant consequences for both community mission and business performance, even if they cannot be measured with precision.

The reasons hospitals invest in frontline workers fall into four broad categories.

- Addressing human resources and labor market challenges;
- Employee morale and motivation;
- Performance improvement; and
- Organizational mission.

## ADDRESSING HUMAN RESOURCES AND LABOR MARKET CHALLENGES

The labor market is the most common motivator for investing in frontline workforce programs, based on our interviews. Compelling needs to fill positions lead hospitals to build “pipelines”—internally, from frontline to higher-skilled positions, and externally, from the community into entry-level. The labor shortages may be in clinical areas—nurses or nursing assistants, in many cases—or in a variety of allied health roles, including surgical, medical laboratory, monitor, or central processing technicians.

Of course, the need to fill specific workforce roles varies considerably over time, as the ebb and flow of demand cycles for registered nurses suggests. Yet hospital workforce efforts are generally traceable to a particular “pain”—a gap in staffing, skill, or retention—that interferes with delivering optimal patient care. “[It’s] the thing that keeps the CEO up at night,” as one executive phrases it.

## RESPONDING TO LABOR SHORTAGES: OWENSBORO MEDICAL HEALTH SYSTEM

In 2006, Owensboro Medical Health System in Kentucky faced a shortage of over 500 nurses. With the assistance of *Jobs to Careers*, a work-based learning initiative funded by the Robert Wood Johnson and Hitachi foundations, OMHS initiated an accelerated, on-site registered nursing program with Owensboro Community & Technical College. For “OCTC@OMHS,” the hospital recruited nursing candidates from a variety of frontline positions, including nursing aides, pharmacy technicians, and unit clerks. With intensive coaching, paid release time, and curriculum developed with the hospital to increase success in math and other basic skills, the program attained retention rates of 75 to 89 percent, comparable to or exceeding national retention rates in Associate’s degree nursing programs.

Hospitals have also initiated workforce programs to support new lines of business. Florida’s Blake Medical Center developed training that would prepare current staff to offer trauma services, in line with newly adopted state requirements for specific competencies and certifications. And in Kentucky, the adoption of new business models by Norton Healthcare led to an investment in training medical assistants for a higher level of critical thinking.

Even though the recession has slowed turnover and lessened demand for new hires, staff retention has been a strong motivator for workforce investments, and turnover remains generally higher at the lower echelons of the health care workforce than at higher levels. Moreover, as Rhode Island’s Michael Paruta notes, “The recession hasn’t stopped anyone from aging.” With an aging workforce and a rapidly aging population, labor shortages in health care—particularly among those responsible for geriatric care—will inevitably return.

Alan Jones, former corporate vice president for human resources at Cincinnati’s UC Health System, sums up this situation: “*Though recruiting is easier in the down economy, we always need employees to fill jobs. We’re paying less attention now, but shortages will return because of the medical needs of the aging population and the pent up retirement plans of older workers.*”

Pipeline programs also support the business case by improving professional recognition for a facility. For example, Bill Lecher of Cincinnati’s Health Careers Collaborative notes that achieving magnet hospital status depended in part on filling enough Bachelor’s of Science-level nursing positions.

## METHODS AND METRICS FOR DOCUMENTING THE IMPACT OF ADDRESSING LABOR MARKET CHALLENGES

- Turnover/retention rates
- Vacancy rates
- Days required to fill vacant positions
- Orientation time (days required to bring new hires up to productive performance)
- Overtime costs
- Temporary agency usage and costs
- Recruitment costs (agency fees, advertising, orientation, and training)

## EMPLOYEE MORALE AND MOTIVATION

The impact of improvements in employee morale and motivation are harder to measure than benefits associated with labor market challenges, although they may be identified at least in part through surveys of employee engagement. Program leaders and executives speak of the improved morale associated with workers who become more self-confident or who feel more empowered. Workers who are less engaged, as Molly Seals of Youngstown, Ohio's Humility of Mary Health Partners, explains, are less committed to delivering quality care or to contributing to the care team. Offering them education, training, and career services has the power to change their views of themselves and, in turn, their behavior as valued and valuable members of a health care workforce.

### EMPOWERING A FRONTLINE WORKER: HUMILITY OF MARY HEALTH PARTNERS

Suzanne A. dreaded to come to work, not feeling good about her contribution as an employee of Humility of Mary Health Partners. After training in “professionalism” and attaining a certificate as a health care associate (a nurse aide), her feelings about working with higher-educated professionals changed radically. Coaching helped her along a pathway that led to a certificate and an important salary increase, even though it was small. According to Molly Seals, vice president of human resources at HMHP, Suzanne began “feeling like I made this contribution and I can do this again.”

For HMHP's workforce director, Kristina Miller, increased skills and knowledge contribute to engagement. The apprenticeship the hospital established to train frontline workers as health care associates and unit clerks gave students a sense of “why” they did certain tasks, not just “how.” Nurse-supervisors attest to this as well, reports Miller. More knowledgeable, better-engaged workers, in turn, are more attuned to the nuances of their patients' conditions. Miller and her colleagues believe that higher patient satisfaction scores reflect a higher level of employee engagement (although HMHP has not formally documented this). Here, as well as at Boston's Beth Israel Deaconess Medical Center, leaders see a clear connection of investments in workers to increased employee loyalty and reduced turnover.

These on-the-ground experiences mirror research in human resources, which has found a strong association between the level of employee engagement and such factors as motivation and intention to quit. This research has also found connections between certain work practices (e.g., teams, career ladders, flexible work arrangements) and increased attachment to the firm (see Becker & Huselid 1998; Becker et al. 1997; Boxall 2003; and Combs et al. 2006).

Workforce program leaders also point to the beneficial effects of their initiatives on group cohesion and teamwork. Leaders described the “cultural change” that takes place as investments in frontline workers challenge traditional medical hierarchies and departmental silos. When frontline workers acquire new skills and certifications, not only do they see themselves differently but so do their peers and colleagues in more formal professional roles.

Humility of Mary Health Partners and Jackson's Central Mississippi Medical Center make specific investments in core behavioral competencies (“soft skills”) training, on such topics as

professionalism, teamwork skills, and communication. That these hospitals perceive a benefit from the strategy reflects the growing importance of effective and coordinated care teams—for the patient-centered “medical home” model as well as for quality care more generally. It also reflects the increasing diversity throughout the hospital ranks, the importance of recruiting and promoting diverse team members, and the desire to foster effective interpersonal skills tailored to a diverse environment.

Hospital leaders also emphasize the bottom-line effects of heightened employee commitment. In this view, employer investments in frontline workers help create a more loyal workforce, one that is less prone to turnover. Asked about the primary benefits to Norton Healthcare of its workforce programs, chief human resources officer Tony Bohn stresses “loyalty effects”: *“Our motto is, ‘We’re developing owners, not developing renters.’ The more we invest in our people, the more we find them sticking with us.”*

The morale-boosting effect of workforce programs can create ripples beyond the employees served directly. Columbine Health System’s Yvonne Myers believes that even when a person cannot take advantage of the program, “they see we care about employees by our investment in their colleagues.” It can also translate into enhanced recruitment via word of mouth in the community. Hartford Hospital’s Leticia Colon spoke of the impact of grateful employees talking up the hospital and its programs; most of her applications result from word of mouth. Columbine views its workforce programs explicitly as a recruiting tool. And at Norton, Bohn cites reputation as a key benefit; this system was the first in Kentucky to create and implement a certification for sterile process technicians.

#### METHODS AND METRICS FOR DOCUMENTING THE IMPACT ON EMPLOYEE MORALE AND SATISFACTION

- Employee engagement and satisfaction measures (from surveys)
- Attendance (absentee rates)
- Turnover/retention rates
- Employee diversity (e.g., by profession, department, separation rate)
- Testimony (interviews with worker/students, peers, and supervisors on the impact of workforce programs on individual morale and group cohesion)

#### PERFORMANCE IMPROVEMENT

Performance improvement as a benefit has two closely related dimensions. One is the skills and capacity of an individual worker to perform his or her job effectively. The other is the ability of the health care provider to meet its own as well as external performance standards for delivering quality care. Hospital leaders speak of heightened standards in the latter case—driven by changing organizational strategies and models, and, in particular, by national policy changes, from the Affordable Care Act to the federal government’s growing use of performance metrics. Changes in process and technology (e.g., in operating room sterile procedures; in the conversion to electronic health records) also change performance standards and skill requirements for workers, including those in frontline positions. So does the adoption of lean production, continuous quality improvement, or other management models.

At the Central Mississippi Medical Center, there is an increased need not only for nurse aides but also for these frontline caregivers to be well-versed in interpersonal skills. As education director Jacqueline Andrews explains, reimbursements for hospitals from the federal Center for Medicare and Medicaid Services will soon be based, in part, on patient satisfaction, as measured by the Hospital Consumer Assessment of Healthcare Providers and Systems patient satisfaction survey. Attaining high HCAHPS scores requires attentive caregivers who respond promptly to call lights and are versed in “pillow-flipping” skills—a shorthand for the interpersonal skills of communicating with and attending to patients. The hospital has adapted its work-based learning model for training unit clerks, developed through *Jobs to Careers*, to create an internal pipeline for skilled bedside caregivers. In Andrews’ words, “*With reimbursement tied to patient satisfaction, everybody has to be on top of customer service.*”

Even more consequential—for patient safety as well as for reimbursement—is reducing errors. For example, the performance of medical coders directly affects reimbursements for the provider: coding errors can cost a large hospital as much as \$3 million per year. In another example, surgical technicians and central processing technicians, who help maintain instruments in the sterile environment of an operating room, must meet rising national certification requirements around quality and safety in hospitals. Children’s Hospital Boston cited those requirements as a reason for offering CPT training. At Blake Medical Center, where surgical technicians must meet Florida’s new skill requirements, the hospital is facilitating more convenient hours and funding for workers to earn certification. For Baltimore’s Good Samaritan Hospital, meeting federal performance metrics created impetus for employee learning. Joanne Eich, director of professional development and education at GSH, explains: “*Quality of care measures also motivate us, because clinical outcomes are not as good when the adequately skilled staff are not at the bedside. We need more qualified staff in order to keep those scores high.*”

Additional metrics used by federal agencies add impetus to investing in employee skill and performance upgrades at all levels. These include measures of the rates of hospital-acquired infections, pressure ulcers, patient falls, readmission, and preventable conditions. The Center for Medicaid and Medicare, the key federal agency in terms of hospital and long-term care provider reimbursements, publishes such measurements for individual hospitals in its “Hospital Compare” website, [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov). It also publishes data from the HCAHPS patient satisfaction survey: [www.hcahpsonline.org](http://www.hcahpsonline.org).

When frontline workers upgrade their skills, the value proposition does not end with the individual’s performance in their present jobs. When a worker takes on broader roles, or performs traditional roles more effectively, higher-skilled staff can expand their capacities as well—to “work at the top of their license.” This has been the incentive for some hospitals to upgrade the clinical care skills of frontline workers in areas such as wound treatment. “Nurse extenders” in Baltimore and “clinical technicians” in Austin enable the care team, particularly nurses, to focus more effectively on patient care. Conversely, at Ohio’s Humility of Mary Health Partners, low skill levels of health care associates (part of the frontline clinical staff) diminished the quality of support provided to licensed clinicians and managers on the team.

Similar benefits are found in other health care workplaces. Health care providers speak of the value that skilled frontline workers could add to the care team in ambulatory care. Health care reform and cost control issues have brought coordination of care (on the patient-centered “medical home” model) to the forefront. With education and training, frontline staff, such as patient greeters or medical assistants, can provide more assistance in capturing needed information (e.g., insurance, demographics, follow-up on outside appointments), freeing up licensed professionals to focus on goals central to quality care: coordination, wellness, prevention.

Productivity and efficiency are chief concerns for health care providers, particularly given cost constraints and mandates to treat rising numbers of the newly insured. At Seattle’s Virginia Mason Medical Center and Boston’s Beth Israel Deaconess Medical Center, one response is to emulate the “lean production” techniques applied more and more widely in manufacturing. In health care, this translates into adjustments in work processes to improve service to patients—for example, reducing wait times at the pharmacy. Frontline workers—medical assistants in the case of Virginia Mason; central processing technicians at Beth Israel—become pivotal to quality improvement.

#### METHODS AND METRICS FOR DOCUMENTING THE IMPACT OF PERFORMANCE IMPROVEMENT

- Error rates (including medical and administrative errors)
- Hospital readmission rates
- Hospital-acquired infection rates
- Patient fall rates
- Hospital-acquired pressure ulcer rates
- Patient satisfaction surveys
- Change in revenue levels (from reimbursements or new or enhanced service lines)
- Interviews with peers, supervisors, and managers

### ORGANIZATIONAL MISSION

Investing in frontline workers “is just the right thing to do,” according to Michael Paruta, workforce director at Rhode Island’s Women and Infants Hospital. Beverley Jackson, executive director for human resources at Washington Adventist Hospital, notes CEO Bill Robertson’s regard for “the value of each employee as a person.” These leaders point to the intrinsic value of workforce programs. Humility of Mary’s chief nursing officer, Kathy Cook, and its vice president for human resources, Molly Seals, say that the primary benefit of such programs is they enable lower-tier workers to advance. As Seals asks, “Are we preparing them to be all they can be” and to view their job as a beginning to a career? Leaders at Blake Medical Center ask, “How can you not invest?”

In this view, investment is driven by a commitment to the staff and the community. While such beliefs are strongly and sincerely felt, they can also bring material benefits. Evidence of providing tangible community benefits can be a factor in maintaining nonprofit status, for example. It may even be a bargaining chip when strapped municipal governments lean on

hospitals and other tax-exempt institutions to increase payments in lieu of taxes. Even for world-class teaching and research organizations, such as University of Cincinnati Hospital or Partners HealthCare in Boston, serving the community is core to the mission. For Partners, according to workforce development manager Mary Jane (MJ) Ryan, providing economic stability to community residents—while filling the pipeline with diverse, well-qualified job candidates—is one of the system’s three strategic goals.

Creating a diverse health care workforce—one that reflects the makeup of the community and the patient population—can also be critical to organizational mission. Interviewees at Partners and at Seton HealthCare in Central Texas cite diversity in race, gender, and other attributes as a key driver of workforce pipeline programs for advancing incumbent workers into higher-level roles. While this is sometimes characterized as an intangible benefit of investing in the frontline workforce, diversity is seen increasingly as central to delivering good care and achieving patient satisfaction. A report from the American Hospital Association’s Quality Center underscores this connection (Anderson, McLaughlin, & Smith 2007). Culturally and linguistically competent health care staff—people who “look like us”—can make a difference in explaining discharge instructions to patients, ensuring better follow-up, and reducing readmission rates. Geronimo Rodriguez, Seton’s vice president for diversity and community outreach, is a strong proponent of this view: *“If you’re a hospital and doing everything right, it’s not much good if you can’t communicate with patients.”*

#### METHODS AND METRICS FOR DEMONSTRATING ALIGNMENT WITH ORGANIZATIONAL MISSION

- Patient satisfaction surveys (including the Hospital Consumer Assessment of Health Care Providers and Systems)
- Recruitment rates (based on word-of-mouth referrals)
- Qualitative interviews with participants, family members, supervisors, and managers
- Illustrative profiles of successful training candidates, demonstrating the impact of skill-building and career investments
- Number of stories on frontline worker participants placed in internal and external media
- “Hits” to online newsletters and other sources
- Diversity in frontline, mid-skill, and professional occupations, benchmarked to a regional demographic profile of working-age populations

# USING AND APPLYING METRICS TO MAKE THE INVESTMENT CASE

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Hospitals make the case for frontline worker investment in myriad ways, but how do they know that these investments make a difference? Leaders interviewed for this guidebook—as well as the executives they report to—have differing standards of evidence. While few conduct formal return on investment analyses, several point to evidence of impacts on costs and cite measurements to back that up. And one hospital partnership—Health Careers Collaborative of Greater Cincinnati—undertook a formal ROI study, in collaboration with a National Fund for Workforce Solutions collaborative, the Greater Cincinnati Workforce Network. It produced powerful results: the employer’s return on investment was nearly 12 percent (see *box on page 21, “The Return on Investment for Career Pathways”*).

Appendix II collects and summarizes the metrics described in this guide.

Nearly every hospital does undertake some level of data collection and analysis. This can take any of several forms:

**Tracking student progress in training and education, including retention in programs, course completions, degrees and certificates attained, and career progression.** Some hospitals and partnerships collect this data primarily to respond to funders, but many do so as a means of gauging the impact of workforce efforts on employees, as well as the strength and quality of programs.

At Blake Medical Center, Human Resources collects data on course participation and completions, as well as worker satisfaction with education benefits. This has helped workforce program leaders persuade other departments, as well as the CFO, to continue investment. Other hospitals have combined standard HR data, such as training hours per worker, with wage and promotion statistics, employee engagement, and other metrics to assess outcomes for employee development.

Beth Israel Deaconess Medical Center’s “Employee Career Initiative” prepares workers who are not ready for college-level studies to attain the skills and complete the courses required for success in the hospital’s allied health pipeline programs. Program staff monitor student progress and achievements, based on initial placement scores, grades, and subsequent placement in college-level reading, math, and English, as well as the completion of prerequisite courses (e.g., biology, anatomy, and physiology). According to an external evaluation, between 2007 and 2010, the initiative enabled 120 employees to enter college-level courses (Hebert 2011). The hospital has continued this program, which was initially supported by grants, with operating funds.

**Tracking traditional human resource metrics, including turnover, vacancies, separations, attendance, and related costs (e.g., overtime pay; costs associated with temporary agencies).** Most of the larger institutions in this study collect standard human resources data on a regular basis, though typically not to measure the specific impact of frontline worker programming. A key virtue of these metrics is that an infrastructure is in place—in terms of staffing or external organizations, protocols, and well-established analytic methods—to harvest data that can be put to use, potentially, for making the business case for investing in the frontline workforce.

**Measuring impacts specific to frontline workforce investments.** While few hospitals monetize these impacts, they contribute real value in the eyes of workforce staff and leadership in the institutions. Reducing the costs associated with turnover is particularly compelling, especially in the current economic climate. In a few cases, as noted, hospitals have deliberately sought quantifiable “bottom line” measures of program impact.

Baltimore’s Good Samaritan Hospital, while not conducting a formal ROI analysis, collects a variety of data to document the benefits of its workforce development programs, including

#### MAKING THE CASE IN BALTIMORE: GOOD SAMARITAN HOSPITAL

*Larry Beck, former president and now a consultant to Good Samaritan Hospital, presents the value proposition for employee pipeline programs, in this excerpt from an interview conducted by the Hitachi Foundation:*

Hospitals are primarily people taking care of people. It is the biggest piece of what is important to a hospital. And it takes on significance in that there is an ROI.

A, you develop these programs, which then help fill your ‘hot jobs’ that you’re struggling [with].

B, you’re reducing turnover, so you’re not filling in as often, and [paying] all the costs [associated with] turnover, which instead reduces your reliance on agency personnel, which is always paid at a premium. It also reduces your overtime costs.

And in the long run, you have a stable workforce with lower costs associated with it. And then you have a better motivated workforce because, when I pay attention to your personal career goals and agendas, you then feel more dedicated to the goals we’re trying to achieve as an organization. It’s been shown time and time again through research that if you’re focusing on the individual personal needs of your workforce, they respond very positively—with retention, with progression, skill set acquisition, providing better care, better patient satisfaction.

So there’s a dollar return on investment in terms of reduced turnover, reduced agency use, reduced overtime, but also an improvement in the quality of services you’re providing because of the motivation of the workforce. And we’ve seen all of that. I think the return on investment is worthwhile. It’s the right thing to do, and we want to keep doing it.

*Good Samaritan Hospital has considerable data verifying Beck’s statements (Beck 2009). The level of agency use fell dramatically in the past decade, during a time of expansion in various pipeline programs to develop nurses and allied health professionals. For example, the number of registered nursing agency full-time equivalents fell from over 45 annually in FY 2004 to 11 in FY 2009. Reliance on agency FTEs for respiratory therapists fell by a similar proportion. Employee retention overall rose from 83 percent to 87 percent during this period, while increased retention for Licensed Practical Nurses was even greater, rising from 75 percent to over 88 percent.*

First Span, a project to train “multifunction technicians” and nurse extenders. These data include changes in turnover (particularly annual retention rates for LPNs and patient care associates), the use of temporary agencies (notably in nursing and respiratory care), expenditures on recruitment, employee satisfaction, and patient outcomes and satisfaction. Explains Joanne Eich, director of professional development: *“We also look at qualitative measures. We ask in orientation, ‘Why did recruits join Good Samaritan?’ And many incumbent workers tell us that this investment is why they stay.”*

Another partner in the Baltimore Alliance for Careers in Healthcare, the University of Maryland Medical Center, compares the retention rate of career advancement participants to that of employees hired by traditional means. According to career development services manager JoAnn Williams, 78 percent of participants have been retained in employment since 2007, versus 58 percent of traditional hires.

At UPMC Hamot, serving Northwestern Pennsylvania, systematic measurement of turnover rates among frontline workers has helped build a compelling case for workforce development. In 2010 UPMC Hamot with support from the Erie Community Foundation and the Northwest Healthcare Industry Partnership began a pilot to recruit, hire, and train low-income residents as Patient Care Assistants. Guided by career development coordinator Rick Cornwell, the PCA program offers job readiness and clinical education, extensive coaching, and career navigation. Cornwell and his colleagues in human resources measured turnover among PCAs at baseline for the program and after a year of program experience. The results are startling: turnover fell from 23 percent to 8 percent for the occupation. The savings per student, estimated conservatively, were about \$10,000, or one-third of annual starting salary. (According to Cornwell, some in the field place the cost of replacement much higher, at 1.5 times an individual’s salary.) Cornwell has presented this data to UPMC Hamot’s HR director, who in turn shared them in meetings with other University of Pittsburgh-affiliated hospitals. This helped stimulate interest in replicating the program throughout the corporation.

Well-designed and carefully chosen metrics can contribute to a bigger payoff from workforce investments, by ensuring that programs target specific needs and support a hospital’s strategic direction. This means using data to track labor supply and demand for specific occupations (e.g., nurses, lab technicians) and specific skill sets (e.g., knowledge of the latest medical codes; customer service). It also means gauging the impact of educational programs: What benefits did they create for the hospital and its staff, patients, and the community?

## BUILDING CAPACITY TO TRACK METRICS: NORTON HEALTHCARE

Norton Healthcare in Kentucky has designed a set of spreadsheet-based tools related to two functions: workforce planning and impact analysis. Norton staff designed the tools in-house after failing to find a vendor who could offer a platform that met the hospital's needs.

In 2008, Norton leaders noted that the hospital was funding a large number of workforce development projects and receiving a wide variety of requests for new projects every year. However, the hospital had no strategic system for selecting among possible projects. In response, Norton's Talent Acquisition and Workforce Development department developed a workforce development metrics system to analyze the characteristics of the hospital's current workforce and the outcomes of each of its training and development programs. These tools have yielded data on which to base decisions and set priorities among workforce programs.

As a baseline, staff inventoried all the occupations at Norton and began tracking the ages and tenures of each employee. This helped the hospital to identify demand for certain types of employee, as well as to predict future openings based on retirements. For example, the data indicated a large proportion of medical technologists were nearing retirement age. HR staff have used these data to understand current and long-term workforce development needs. They also use them to inform employees and jobseekers about career advancement opportunities (e.g., moving from medical lab technician to medical technologist) that might come from various educational choices.

In addition, the data system helps Norton track the effects of its programs on retention and hiring. One example is the "Norton Scholars" program, a tuition forgiveness program that allows current and prospective employees to pay off college tuition debts of up to \$6,000 per year (\$24,000 total) through work at Norton after graduation. Using the metrics system, Norton calculated that among employees who completed the Scholar program in 2010, turnover was 5 percent, compared to non-scholar participants, which had turnover of 31 percent. Comparing RNs trained through Norton Scholars to non-scholar RNs over a four-year period, Norton staff estimated that there were 61 fewer terminations than there would have been without the program, a savings of over \$5 million to the hospital.

Tony Bohn, Norton's vice president and chief human resources officer, expresses the power of this data in presentations to managers, who "are not used to HR having business-related data." Armed with this data, "No one has ever said no to us on proposals for new programs."

## THE RETURN ON RETURN ON INVESTMENT

Demonstrating positive net returns on workforce investment sends a powerful message—to CEOs, CFOs, and other decision makers who hold the purse strings of institutions with billion-dollar balance sheets. In the words of the University of Cincinnati Health System's Alan Jones, the business case for this investment is "all about the money. *While employers will do what is right, none can afford to simply lose money as a result of new programs.*"

Indeed, the results of Health Careers Collaborative’s ROI study were used in discussions with senior hospital leadership at UC Health System about the fate of workforce programs. (For more details on methods employed and findings of the collaborative’s return on investment analysis, see the box and Appendix III.)

#### THE RETURN ON INVESTMENT FOR CAREER PATHWAYS: HEALTH CAREERS COLLABORATIVE OF GREATER CINCINNATI

The Greater Cincinnati Workforce Network and the Health Careers Collaborative (HCC) of Greater Cincinnati commissioned the *Return on Investment Report: 2011*, conducted by the NewGrowth Group (Elvery & Spence 2011). The study looked at the costs and benefits to employers of participating in HCC, and specifically career pathway programs that result in Associate’s degrees and certificates in health occupations.

UC Health System, one of HCC’s founding employers, made all necessary data available and worked extensively with the consulting team to design the study. This process was challenging because it required familiarizing non-hospital researchers with hospital terminology and costing, and hospital executives wanted to ensure that benefit measurements used would not be disputed. For that reason, they focused on direct recruiting and training costs.

Even before the publication of the ROI report, the hospital system put the measurement information to use in making a critical decision about continuing the programs under study. The system was going through major restructuring and budget cuts, having shrunk from seven hospitals to two. When the senior vice president of human resources asked Jones if the HCC program was worth keeping, the principal evidence for doing so was that it was earning \$1.12 for every \$1.00 invested.

# CHALLENGES TO THE MEASUREMENT AND USE OF METRICS

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Measuring the impact of any organizational process, be it medical techniques, technology use, or health and safety procedures, can be complex and challenging. It requires substantial planning, it is labor intensive, and it does not always yield usable results. This is no less true when assessing the value of investments in frontline workforce development.

**At the planning stages, it is critical to determine what to measure, and why.** Alan Jones, University of Cincinnati Hospital's vice president of human resources, stresses that before conducting ROI studies—whether of career path programs or tuition reimbursement—proponents clearly define the values that are real for the executive team (e.g., turnover costs, recruiting costs, performance ratings). Jones advises that the hospital challenge itself on the question of what is of value. Of course, as the examples here illustrate, not all that providers value is equally or easily measurable. In addition to the net benefits expressed in dollar costs, Health Careers Collaborative employers informed ROI researchers of several types of benefit omitted from the analysis as incalculable in dollar terms. These include increased staff diversity, provision of advancement opportunities, increased morale, and fulfillment of the community service mission.

**Having decided what to measure, providers must answer the question, “Compared to what?”** Is it better to compare turnover to an industry standard or to standards established by the hospital? If progression of employees into higher-skilled positions is the focus, what is the appropriate comparison group? To eliminate potential sources of bias in their research, ROI analysts for Cincinnati's Health Careers Collaborative took care to make allowance for job tenure and experience in determining the impact of educational programs on participants and comparison group members.

**Collecting data and making them usable can be equally challenging.** Systems and platforms used in different hospital departments may not mesh, as ROI analysts working with Cincinnati's hospitals discovered. Data on employee participants, particularly after leaving workforce programs, may be missing, incomplete, or raise concerns about privacy. And even the largest institutions may lack the staff capacity (time, skills) to create and apply metrics from raw data. Learning to make data usable is a difficult and time-consuming task. Some organizations rearrange the work of staff to get this done, while others secure outside funding to support a position, as UPMC Hamot did with a grant from the Erie Foundation. Ideally, a hospital makes a cross-department, multidisciplinary team responsible for overall metrics. Children's Hospital Boston plans to hire a financial analyst to support the ROI work of human resources and the director of business operations.

**A major challenge to developing accurate metrics is attribution.** With how much confidence can we say that a program for employee learning or career advancement lowered turnover, particularly when unemployment rates are high? Similar questions can be asked about impact on enhanced morale and improved patient satisfaction. Attribution of program impact to the financial bottom line is also complicated. Given the modest size and duration of many workforce programs, and the range of factors informing such outcomes, connecting the dots accurately between program cause and effect is often difficult.

A report from Aspen Institute’s Workforce Strategies Initiative sheds light on these challenges (Blair & Conway 2011). It draws on Aspen’s experience with a tool it developed, the Business Value Assessment, to determine an employer’s benefit from workforce programs. The authors counsel users about when a business value approach is most appropriate, and when it is less so. For example, very small programs, or when training cohorts are small or scattered across many business units, may not yield meaningful data about business impacts.

**Timing is critical.** External events loosely or not related to the services concerned may complicate measurements of the impact of training. This could include changes in the economy or decisions made at the firm level (e.g., a key executive’s departure). Aspen researchers note a case of a manufacturing firm that sought to measure the productivity impact of a training project. The firm’s decision to relocate directly after the training period confounded any findings about impact. A hospital’s sudden merger or acquisition by a health care system could introduce similar complications. Evaluations address such issues in part by being transparent about assumptions made and potential limitations that might compromise findings.

**Perhaps the clearest challenge to developing and using metrics is the opportunity cost.** The ROI on staff time to design metrics, collect data, and produce reliable findings is uncertain, especially when compared with other activities more closely tied to health outcomes. For some executives and other senior leaders, elaborate metrics or ROI analyses are unnecessary to make the case for frontline workforce investment; a few key metrics or “data points,” in Michael Paruta’s words, may suffice. For others, good metrics alone may not, given cost pressures, low profit margins, and other factors in the economic or policy environment. In all cases, decisions about what metrics to use (or whether to use them at all) must be strategic and grounded in value—what stakeholders in an institution consider to be most important, and relevant, for accomplishing their mission.

# RECOMMENDATIONS FOR MAKING EFFECTIVE PRACTICE STANDARD PRACTICE

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This guidebook does not offer a recipe for producing business metrics. Rather, it is an invitation to hospitals to join a conversation about the potential value of “growing their own” skilled workforces—and building a learning culture to support this effort. We are indebted to the employers and their partners who sparked this conversation by sharing their insights and experiences, and we will work with users of this guide to expand on the examples provided here.

In the spirit of furthering this vital conversation and making an effective case for taking good practices to scale, we offer several recommendations:

**Move from “boutique” projects to “business as usual.”** Determine strategies for institutionalizing and scaling up good practices in the development of the frontline workforce. Hospitals leaders offer these starting points, among others:

- Cast a wide net within the hospital, engaging allies beyond human resources and staff education, such as managers in various clinical units, as well as senior leadership.
- Address workforce development, particularly for frontline and mid-skill positions, at a systems level rather than making the case piecemeal to one manager at a time within a single hospital.
- Frame the case in terms of talent management and succession planning. To meet long-term workforce needs and quality goals, providers will need to consider the entire workforce, not just senior management and licensed professional staff.
- Acknowledge that building internal pipelines with measurable impacts takes time, especially when workers come with low basic skills or are not ready for college-level studies. Building an internal pool of candidates for critical positions can take five years or more; adjust expectations and metrics accordingly.

**Continue gathering intelligence and checking assumptions against practice.** Disseminate this guidebook to a wide audience of health care providers to validate the practices and metrics presented here and to supplement or revise them as necessary.

**Don't reinvent the wheel.** Adopt and customize existing templates and practices to your own practice. Establish common templates and collection tools for use by other organizations in the region (e.g., community colleges, public workforce agencies, community-based organizations). Where partnerships or consortia exist, arrange to share costs as well as data when appropriate.

**It's not just about recruitment.** Given the lingering effects of recession, a business case based on labor shortage is less convincing than one grounded in performance upgrading and consumer-centered care.

**Set a high bar.** Establish the practices and metrics used by these hospitals as benchmarks for other providers, health care systems, and state and national associations.

**Create rewards for building better metrics.** Advocate for the creation of a competition and awards (or other recognition) for development and application of business metrics to frontline workforce investment.

**Remember that measuring impact is as much art as science.** Not all benefits can be monetized or even quantified. The strongest case is usually made with multiple methods, combining “hard” data (e.g., retention or cost figures) with textured portraits of individual workers and perceptions (from interviews) of what supports career advancement.

**Foster business-to-business learning.** Establish formal and informal learning networks to stimulate the adoption of good practices and metrics and cultivate champions in additional hospitals. For example, an online index of providers and practice information or an “open source” repository for documenting use of metrics and discussing results and reactions would aid in developing the field and establishing common standards.

**Move the policy debate.** Government and educational systems have been key partners with employers in developing the frontline health care workforce, but much more needs to be done. Develop advocacy strategies and coalitions to inform federal and state health care workforce policy. Build alliances with the education and workforce communities. Incorporate lessons from advocacy for the direct care workforce (serving elders and persons with physical or mental disabilities). Find common cause among employer, worker, and consumer advocates in linking quality jobs to quality care.

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# APPENDIX I. GOOD PRACTICES IN FRONTLINE WORKFORCE DEVELOPMENT

Hospitals and other health care providers seeking to invest in their frontline workforce can adopt a wide range of proven practices from the field—many drawn from the organizations leading and participating in CareerSTAT. This list of suggested practices is far from exhaustive, yet it illustrates the comprehensive and systematic approach that leading employers have taken to “growing their own” health care workforces from within the workplace and the community.

## CAREER ADVANCEMENT

- Coaching and mentoring
- Career counseling
- Individual learning plans
- Career ladders (adding new “rungs” or wage increments to an occupation corresponding to higher skill and responsibility)
- Career maps, illustrating structured steps and multiple pathways within and between occupations
- Case management (services or referral information on child care, transportation, finances, or other needs)

## ENHANCED TRAINING AND SKILL DEVELOPMENT

- Recruitment from the community, possibly in collaboration with community-based organizations
- Structured orientation (general and on the unit)
- Instruction in job readiness and core behavioral competencies (“soft skills”)
- Apprenticeships
- Job shadowing and mentorship
- Training to upgrade job performance to meet elevated standards or competencies

- Training in skills and competencies necessary to optimize job performance

## **EDUCATIONAL SUPPORTS**

- Assessment for skill level, educational needs, and/or career interests
- Basic skills instruction in reading, math, or other foundational skills
- Precollege courses at the workplace
- Computer instruction and preparation for online learning
- College placement test administered at the workplace
- Tuition advancement or remission; educational loans
- Tutoring, study skills development, and other academic supports
- Workplace learning during work time (or combining work and employee time)
- College instruction at the workplace; college credit earned at work
- Release time to attend classes or training
- Contextualized instruction; accelerated or compressed degree programs
- Competency-based learning, leading to certification of mastery

## **REORGANIZING WORK AND THE WORKPLACE**

- Dedicated workforce development units or staff
- Expanded or redefined job responsibilities
- Cross-functional or interdisciplinary teams
- Supervisors serving as instructors or coaches
- Supervisors or managers serving as adjunct college faculty
- Supervisor and manager performance assessed on the basis of workers' skill development and career growth

## APPENDIX II. CAREERSTAT COLLECTED METRICS

For ease of reference, this appendix collects and summarizes the metrics described in the *CareerSTAT Guide* and listed in the accompanying table, “Metric by Type of Program Impact.” It provides expanded definitions, where necessary, and additional references and examples.

### METRICS FOR DOCUMENTING IMPACTS OF ADDRESSING LABOR MARKET CHALLENGES

- **Turnover rates:** The percentage of a workforce that terminates employment in a given period, such as one year. Turnover rates are generally higher for frontline occupations, such as housekeeper or patient care assistant, than for higher-paid and licensed positions. A related metric, retention rates, measures the percentage of employees remaining in their jobs after a given period of time.<sup>1</sup>
- **Vacancy rates:** The percentage of positions open for a given occupation in a workplace. This metric can have multiple purposes: as a companion indicator to turnover rates, to gauge the level of stability and employee satisfaction and morale, and as a measure of the success of pipeline programs for preparing internal candidates to fill higher-skilled, vacant positions.

Organizations with high rates of turnover and vacancies in specific positions experience secondary impacts, such as those listed below, that provide further metrics for quantifying the effects of high turnover, as well as workforce programs that can potentially lower turnover or vacancy rates. By charting these costs over time, organizations can measure cost savings related to workforce investments. By comparing savings to the costs of selected workforce education programs, it is possible to calculate return on investment. It may also be useful to compare these measurements to industry-wide (or regional) norms.

### ADDITIONAL METRICS ASSOCIATED WITH HIGH TURNOVER AND VACANCY RATES

- **Days required to fill vacant positions**
- **Overtime costs:** Additional wage and benefit costs required to cover for vacancies
- **Temporary agency usage** and costs (also known as “travelers;” may be measured in full-time equivalents)
- **Recruitment costs:** Agency fees, advertising, orientation, and training

- **Orientation time:** Days required to bring new hires up to competent and productive performance

Hospitals and other health care organizations can also benefit from using metrics of their progress in addressing labor market challenges, as when frontline employees are promoted, through training and career development, to fill vacancies in higher-skilled positions.

- **Internal promotion rates**

## METRICS FOR DOCUMENTING IMPACTS ON EMPLOYEE MORALE AND SATISFACTION

With the exception of turnover, retention, or absentee rates, these metrics primarily measure intangible (or non-monetized) benefits. Human resources departments routinely collect nearly all of them. An exception is the use of specialized, qualitative interviews with staff to capture a more nuanced picture of the perceived impacts of workforce programs.

- **Employee engagement, commitment, and satisfaction:** These measures, routinely gathered through surveys of the workforce, gauge employees' level of emotional attachment to their jobs and, in turn, their level of effort and contribution and their likelihood of remaining in or leaving their employment.
- **Attendance:** Absentee rates
- **Turnover/retention rates** (see page 31)
- **Internal promotion rates** (see above)
- **Employee diversity:** By profession, department, separation rate, age, tenure, etc.
- **Perceived impacts of training:** Interviews with worker/students, peers, and supervisors on impact of workforce programs on individual morale and group cohesion

## METRICS FOR DOCUMENTING IMPACTS OF PERFORMANCE IMPROVEMENT

Performance metrics are gaining prominence for all segments of the health care workforce as public policies (e.g., the Affordable Care Act, federal reimbursement practices) turn the spotlight on quality improvements. While the Center for Medicare and Medicaid Services has long published extensive data on the performance of long-term care facilities, it has only recently provided equivalent measures for acute care providers, using the website “Hospital Compare” ([www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov))

- **Error rates**

The most serious errors are medical, or mistakes committed by health professionals that result in harm to patients. Medical errors can occur in diagnosis, administering

medications, performing surgical or other procedures, using equipment, or interpreting laboratory findings.<sup>2</sup>

**Hospital-acquired infections** are a commonly used metric of preventable harm to patients. These are infections not present and without evidence of incubation at the time of admission to a health care setting.<sup>3</sup> This measure is of particular importance for nurses but will be increasingly important for assessing the impact of skill upgrading and training for frontline workers as the latter assume greater involvement in the care-giving team.

The Hospital Compare website has begun listing data on the incidence of **Central Line Infections**, acquired in intensive care units. These infections affect one in twenty ICU patients and result in death in 25 percent of cases. They are also estimated to cost hospitals \$17,000 per incident, or as much as \$700 million per year nationally.<sup>4</sup> While this metric primarily applies to nursing and other licensed clinicians, it may be relevant.

Administrative errors can also be highly consequential, as when medical coders make errors in assigning correct codes that prevent full reimbursement for medical procedures.

- **Patient care metrics**

Federal and state oversight of long-term care, acute care, and home health providers includes the collection of metrics of patient conditions that are closely related to the performance of caregivers, including frontline workers. These metrics included data on the incidence of patient falls, hospital-acquired pressure ulcers (or “bed sores”), skin care, and other measures related to the health, safety, and psychosocial well-being of patients.

Facilities committed to improving the quality of patient care have focused on staff education in areas such as fall prevention, as well as the identification, treatment, and prevention of hospital-acquired pressure ulcers.<sup>5</sup>

### **Hospital readmission rates**

Depending on the reporting source, readmissions can be defined as any admission to the same hospital occurring within seven, 15, or 30 days after discharge from the initial visit.<sup>6</sup> Since 2009, the federal Department of Health and Human Services has published data on how often Medicare patients with heart attacks, heart failure, or pneumonia are readmitted to hospitals within 30 days of discharge. Hospitals are compared to national averages (“no different,” “better” or “worse” than the U.S. rate for Medicare patient readmission).<sup>7</sup>

- **Changes in revenues** (from reimbursement, new or enhanced service lines). Development of frontline workers through skills training, educational support, and career guidance can facilitate bottom line improvements for hospitals and other health care providers. As noted, reduced error rates, in medical coding and other areas, can help prevent reductions in reimbursement.

Similarly, investment in customer service skills can translate into higher patient satisfaction and enhance reimbursement levels under new federal policies adopted in 2012.

- **Patient satisfaction.** While hospitals have previously surveyed patients on their satisfaction with their care, employing the Hospital Consumer Assessment of Health Care Providers and Systems, such measures have taken on greater financial importance with the announcement, by CMS, that it will withhold 1 percent of Medicare reimbursement based on satisfaction surveys, beginning October 2012, and base 30 percent of bonuses on this basis.<sup>8</sup> Only hospitals receiving a 9 or 10 rating (on a 10-point scale) will be credited by Medicare. While many of the questions are addressed directly to patient experiences with physicians or nurses, some bear on the performance of frontline staff, including patient care assistants, housekeeping or environmental service workers, and dietary staff. Sample questions include:
  - After you pressed the call button, how often did you get help as soon as you wanted it?
  - How often did nurses treat you with courtesy and respect?
  - How often did nurses explain things in a way you could understand?
  - How often was your pain well controlled?
  - How often were your room and bathroom kept clean?
  - How often was the area around your room quiet at night?
- **Perceived impacts of training** (from interviews with peers, supervisors and managers). The performance of workers who have received training in specific skill areas and competencies can be assessed through “360 degree” interviews with colleagues and managers who have observed their work and can address changes in performance.

## **METHODS AND METRICS FOR DEMONSTRATING ALIGNMENT WITH ORGANIZATIONAL MISSION**

- Qualitative interviews with participants, family members, supervisors, and managers
- Illustrative profiles of successful training candidates, demonstrating the impact of skill-building and career investments
- Number of stories on frontline worker participants placed in internal and external media; “hits” to online newsletters and other sources
- Diversity in frontline, mid-skill, and professional occupations, benchmarked to a regional demographic profile of working age populations
- Employee engagement, commitment, and satisfaction, as measured by surveys

- Internal promotion rates

METRIC BY TYPE OF PROGRAM IMPACT				
	Labor Market Challenges	Employee Morale and Engagement	Performance Improvement	Alignment with Mission
Turnover	•	•		
Retention	•	•		
Vacancy	•	•		
Associated metrics				
Days required to fill vacant positions	•			
Overtime costs	•			
Temporary agency usage	•			
Recruitment costs	•			
Orientation time	•			
Employee engagement		•		•
Employee satisfaction		•		•
Employee commitment		•		•
Attendance		•		•
Employee diversity (race, ethnicity, language)	•	•	•	•
Employee cultural competence	•	•	•	•
Internal promotion rate	•	•	•	•

METRIC BY TYPE OF PROGRAM IMPACT (CONTINUATION)				
	Labor Market Challenges	Employee Morale and Engagement	Performance Improvement	Alignment with Mission
Error rates (medical, administrative)			•	
Hospital readmission rates			•	
Hospital-acquired infection rates			•	
Patient falls			•	
Pressure ulcers (hospital acquired)			•	
Patient satisfaction/Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS)			•	•
Change in revenue levels (from reimbursements or new or enhanced service lines)				
Perceived impact (from interviews)			•	•
Recruitment (word-of-mouth referrals)				
Illustrative profiles (success stories)			•	•
“Hits” in mass media and social media				•

## APPENDIX II ENDNOTES

<sup>1</sup> These are the most commonly collected metrics by companies offering workforce programs, according to Corporate Voices for Working Families (2011).

<sup>2</sup> “Medical Errors.” Reference.MD: [www.reference.md/files/Do19/mDo19300.html](http://www.reference.md/files/Do19/mDo19300.html)

<sup>3</sup> “Hospital-acquired infections.” Ayesha Mirza, MD, and Haidee T. Custodio, MD, *emedicine*. [medscape.com/article/967022-overview](http://medscape.com/article/967022-overview)

<sup>4</sup> Kristina Fiore. “CMS Site to Track Central Line Infections.” *MedPage Today*, February 9, 2012.

<sup>5</sup> On the use of measures in demonstrations to prevent falls, see: Wong, C.A., A.J. Recktenwald, M.L. Jones, B.M. Waterman, M.L. Bollin, & W.C. Dunagan. 2011. “The Cost of Serious Fall-related Injuries at Three Midwestern Hospitals.” *The Joint Commission Journal on Quality and Patient Safety*. Vol. 37, No. 2, 81-7. On performance measurement in the prevention of pressure sores, see: Jankowski, I.M. & D.M. Nadzam. 2011. “Identifying Gaps, Barriers, and Solutions in Implementing Pressure Ulcer Prevention Programs,” *The Joint Commission Journal on Quality and Patient Safety*. Vol. 37, No. 6, 253-64.

<sup>6</sup> The Mayo Clinic defines hospital readmission as patient admission to a hospital within 30 days after being discharged from an earlier hospital stay. The standard benchmark used by the Centers for Medicare and Medicaid Services is the 30-day readmission rate. Rates at the 80th percentile or lower are considered optimal by CMS. Source: [www.mayoclinic.org/quality/readmission-rates.html](http://www.mayoclinic.org/quality/readmission-rates.html)

<sup>7</sup> “Vital New Quality Data on Hospital Readmission Rates Available on Hospital Compare Website.” Press release. Hospital Quality Alliance, July 9, 2009.

<sup>8</sup> Pauline Heidemann. 2011. “Hospital Reimbursement Tied to Patient Satisfaction.” *Total Compliance Solutions. The MedSafe Compliance Corner*. Posted November 11 at: [blog.tcs-inc.us/the-medsafe-compliance-corner/bid/67321/Hospital-reimbursement-tied-to-patient-satisfaction](http://blog.tcs-inc.us/the-medsafe-compliance-corner/bid/67321/Hospital-reimbursement-tied-to-patient-satisfaction)

## APPENDIX III. CASE STUDY: ANALYZING RETURN ON INVESTMENT IN CINCINNATI

### THE HEALTH CAREERS COLLABORATIVE OF GREATER CINCINNATI

In 2011, the Greater Cincinnati Workforce Network and the Health Careers Collaborative of Greater Cincinnati funded a consulting firm, the NewGrowth Group, to prepare the *Return on Investment Report: 2011* for its two frontline health worker advancement programs. One was its Associate Degree Cohort Program that offers financial, academic, and social supports for working learners enrolled in one of five Associate's degree programs. The second is a career pathways program for supporting short-term certificate completion, below the Associate's degree level, in nursing, allied health, rehabilitation, health information technology, and biotechnology.

For the Cohort Program, the ROI study focused on two sources of benefits: reduced hiring and training costs of the promoted workers when compared to outside hires (\$24,438 per participant completer); and reduced turnover and associated costs while the participant is in the program (\$2,214 per completer). The study limited the ROI benefit measures to those two based on the availability of clear data.

The largest cost investments were tuition payments (\$12,566 per person) and the cost of filling the participant's prior position (\$9,000 per person). Much smaller administrative costs were also included in cost calculations because most of these were covered by grants. The analysis also included the cost of slightly higher absence rates during training. In both the benefit and cost calculations, absence and recruitment costs were estimated based on prior industry studies combined with average pay for relevant occupations for the Cincinnati metropolitan area.

For the short-term certificate program, the study did not conceptualize the analysis as an ROI because the employer incurred very low costs to implement it—about \$102 per hired participant in the first two years after completion. In this case, the employer-born costs stem only from a small administrative burden and slightly higher absentee rates in the first two years after completion (but lower absenteeism in the third and fourth years after completion). The net benefit to the employer stemmed from lower turnover and reduced recruitment costs, which each made up about half of the \$4,869 calculated benefit.

In methodology, the certificate program analysis used a comparison group of workers matched by start date, occupation, and facility where employed. Using this comparison-worker matching methodology, the study found matches for 462 of the 525 participants. It then compared participants to their matches on measures of turnover, absenteeism, and evaluation

scores. Patient care assistants, a high-turnover job, made up the bulk of participants. Thus, annual turnover rates for both participants and matches remained high; however, 48 percent of participants were retained after 12 months, compared to 37 percent of matched individuals.

A number of assumptions about cost and benefit were necessary in order to make cost calculations in the case of both program analyses. However, the researchers were fairly conservative in those assumptions, basing them on other studies and hospital calculations, and list them explicitly in the study.

This cost study examined the benefits to employers in relation to the costs to employers. Additional costs were supported by grants from foundations through the Health Careers Collaborative. Such funding makes it easier to measure the employer return on investment. It also reflects the community “externality” benefits of helping low-income or previously unemployed workers move out of poverty and into family-sustaining work.

Furthermore, employers in the study report several important benefits not included in the ROI analysis because they were not calculable in dollar terms. Those include: increasing diversity in staff; providing advancement opportunity for staff; improved staff morale; and fulfillment of the hospital’s community service mission.

Yet even excluding those benefits, these career pathways were deemed beneficial to participating employers. The researchers concluded that with a conservative 11.9 percent ROI on the Associate Degree Cohort Program, this benefit is generalizable to other hospitals conducting this type of program. And if the short-term certificate program were included in the analysis, the total benefit to employers would be over \$2.8 million. Relative to the costs estimated in this study, the ROI would amount to 146 percent. (*The report is available on the website for the Health Careers Collaborative of Greater Cincinnati: [www.hccgc.org](http://www.hccgc.org).*)

## **UNIVERSITY OF CINCINNATI HEALTH SYSTEM**

The University of Cincinnati Health System, as one of four institutions in the Health Careers Collaborative, made all of its data available to a consulting research team and worked extensively with it to design the study. This process was difficult because it required familiarizing non-hospital researchers with hospital terminology and costing. However, hospital executives knew the study would be worth the difficulty and gave strong support to the researchers. They also wanted to ensure that the ROI benefit measurements would be accepted widely. For that reason, they ultimately asked that the analysis of their program benefits focus on clear savings from recruiting and training cost.

The research was valuable for evaluating the primary programs and should be generalizable to other hospitals and programs. For example, even before the final report, *Return on Investment Report: 2011*, was published, the measurement information was put to use in making a critical decision about continuing the programs described above. The University of Cincinnati Health system, then called the “Health Alliance,” was going through major restructuring and budget cuts, having shrunk from seven hospitals to two. When the executives asked corporate vice president of human resources Alan Jones if this program was worth keeping, he could make a compelling case in dollar and cents: The program was earning \$1.12 for every \$1.00 invested.

## APPENDIX IV. RESOURCES ON EFFECTIVE PRACTICES IN HEALTH CARE WORKFORCE DEVELOPMENT, BUSINESS METRICS, AND RETURN ON INVESTMENT

**Business Value Assessment.** The Aspen Institute’s Workforce Strategy Initiative designed this method to help practitioners and their employer partners assess the business value of their workforce services. Aspen WSI has developed a handbook explaining BVA and a toolkit containing spreadsheets and questionnaires for collecting and tracking various measures of business value. <http://dev.aspenwsi.org/our-work/tools/bva-toolkit/>

**Tuning In to Local Labor Markets: Findings From the Sectoral Employment Impact Study,** by Sheila Maguire, Joshua Freely, Carol Clymer, Maureen Conway, & Deena Schwartz. July 2010. For this analysis, Public/Private Ventures designed an experimental evaluation of participants in sectoral workforce initiatives managed by Milwaukee’s Wisconsin Regional Training Partnership, Boston’s JVS, and New York’s Per Scholas. The JVS program trained candidates for medical billing and accounting. Researchers found that participants had significantly higher earnings gains, as well as greater likelihood of working and of working in jobs with higher wages and benefits than those in a control group. [http://www.ppv.org/ppv/publication.asp?section\\_id=26&search\\_id=o&publication\\_id=325](http://www.ppv.org/ppv/publication.asp?section_id=26&search_id=o&publication_id=325)

**From Hidden Costs to High Returns: Unlocking the Potential of the Lower-Wage Workforce.** Tony Proscio, 2010. Insight Center for Community Economic Development. This business brief summarizes research that found that these pioneering companies are benefiting financially by investing efforts and resources in employee development for their lower-wage workers and rewarding their growth with significant earnings increases. These employers see workforce development as key to maintaining a competitive edge. They view their lower-wage workers as a valuable asset: a means of continually improving quality and a potential talent pool for higher level positions. [www.insightcced.org/uploads/publications/wd/pdf](http://www.insightcced.org/uploads/publications/wd/pdf)

**Greater Cincinnati Workforce Network, Health Careers Collaborative of Greater Cincinnati. Return On Investment Report: 2011.** This report, prepared by the NewGrowth Group, analyzes the return on investment to a hospital employer, University of Cincinnati Health, for training low-skilled incumbent workers for occupations requiring Associate degrees, as well as the benefits to employers of certificate training programs for low-skilled workers. [www.hccgc.org](http://www.hccgc.org)

**Innovative Workforce Models of Health Care.** Lisel Blash et al. 2011. This is a series of case studies showcasing primary care practices that are expanding the roles of medical assistants and other frontline workers in innovative ways. The organizations selected are implementing practice models that improve organizational viability and quality of care for patients while providing career development opportunities to frontline employees. The Hitachi Foundation supports this research. The case studies are available at [futurehealth.ucsf.edu](http://futurehealth.ucsf.edu).

**Invisible No Longer: Advancing the Entry-level Workforce in Health Care.** Randall Wilson, 2006. This report presents the workforce challenges facing health care, surveys a range of practices for making the workplace and educational institutions “learner friendly” and “work friendly,” and offers recommendations for action.

[jobs2careers.org/resource/invisible-no-longer/](http://jobs2careers.org/resource/invisible-no-longer/)

**Measuring Business Impact in Workforce Development: A Workforce Development**

**Practitioner’s Guide.** Lisa Soricone, Navjeet Singh, & Rebekah Lashman. 2011. This is a step-by-step guide to measuring business impact of sector-based workforce projects, including health care, drawing on the work of Massachusetts’ Commonwealth Corporation. The guide is targeted to both workforce development practitioners engaged in project planning or implementation, inside or outside the workplace, as well as program evaluators. It is available at [www.commcorp.org/resources/detail.cfm?ID=899](http://www.commcorp.org/resources/detail.cfm?ID=899)

**The Pioneer Employers Initiative.** The Hitachi Foundation has documented a number of employers who have found economic incentives for improving the jobs and career opportunities of employees, including many in health care. This website provides links to a number of organizations who have carried out research into employer workforce practices, many of them in health care. For more information, see: [www.hitachifoundation.org/component/content/article/26-pioneer-employers/365-the-pioneer-employers-initiative](http://www.hitachifoundation.org/component/content/article/26-pioneer-employers/365-the-pioneer-employers-initiative).

**Profiting From Learning: Do Firms’ Investments in Education and Training Pay Off?** Laurie J. Bassi, Jens Ludwig, Daniel P. McMurrer, & Mark Van Buren, ASTD, 2000. This American Society for Training and Development study found a significant correlation between what firms invest in work-based learning efforts and their total stockholder return. Of the nearly 600 companies examined in this study, those firms investing in employee development experienced better earnings, a higher return on equity, and better stock performance. Specifically, firms that invest more than the average amount on work-based learning programs have total stockholder returns that are 86 percent higher than firms that invest less than the average, and 45 percent higher than the total market average. The bottom line is that training does create value for organizations. [www.work-basedlearning.org/bus\\_case.cfm](http://www.work-basedlearning.org/bus_case.cfm)

**ROI 360<sup>o</sup>. JOIN: Final ROI Case Studies.** JOIN, the Job Opportunity Investment Network, is a public-private partnership of regional and national funders that invests in, and evaluates, best practice efforts in the education and training of the low-skilled workforce. JOIN developed case studies on the return on investment for employers and workers of workforce partnerships in health care and human services (an independent living center), and in high-technology manufacturing (computer components). It found that businesses captured “significant value” from participating in partnerships and trainings, even if the latter were short term. Workers, on the other hand, accrued greater benefits from longer-term training, involving career paths and credentials. The final report will be made available in March 2012. For details, see [www.joincollaborative.org](http://www.joincollaborative.org)

**Turning Skills into Profit: Economic Benefits of Workplace Education Programs.** Michael R. Bloom and Brenda Lafleur, Conference Board, 1999. On behalf of the U.S. Department of Education’s Office of Vocational and Adult Education, the Conference Board studied 45 national workplace education projects. It found a wide range of benefits, including bottom-line results such as increased profitability, greater employee and customer retention, reduced errors, improved job skills, and increased employee morale and team functioning.  
[www.work-basedlearning.org/bus\\_case.cfm](http://www.work-basedlearning.org/bus_case.cfm)

**Why Companies Invest in “Grow Your Own” Talent Development Models: Including a Tool for Calculating Return on Workforce Readiness Programs.** Corporate Voices for Working Families. 2011. This brief summarizes research conducted by CVWF that sought to calculate whether the education and training investments made by three well-known American companies were effective, and whether they were creating a positive return on investment. The employers—CVS Caremark, Johns Hopkins Hospital, and Pacific Gas and Electric—participated in the research and shared information about their workforce readiness training programs. The report features a companion “Return on Investment (ROI) Tool” designed to help calculate the real dividends associated with workforce education and training.  
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# CAREERSTAT LEADERSHIP TEAM AND PARTNERS

The CareerSTAT initiative is a joint project of the National Fund for Workforce Solutions and Jobs for the Future, supported through a grant from the Joyce Foundation. CareerSTAT was organized to: encourage and promote investments of time and resources into career advancement for frontline hospital workers; assist hospitals to learning about innovative practices successfully used by members of the CareerSTAT network; and provide effective examples of how to measure the business outcomes from these investments.

To promote learning incorporated in the *CareerSTAT Guide* and to spread its learning, a group of hospital leaders have volunteered to serve as members of a CareerSTAT Leadership Team. These individuals communicate regularly, participate in conference presentations, and travel to other communities to encourage participation in CareerSTAT practices.

If you are interested in participating on either the Leadership Team or as a CareerSTAT Partner, please contact Shannon Mason, [smason@jff.org](mailto:smason@jff.org). Additional information about CareerSTAT can be found at [www.nfwsolutions.org](http://www.nfwsolutions.org).

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**NATIONAL INVESTORS**

The national investors provide seed money—\$25 million in commitments to date—to regions for building local approaches to job training and career development. The investors also support a comprehensive evaluation of initiative activities taking place across the country, technical assistance for local partnerships, and a dynamic “national learning community” that helps those partnerships share best practices and solve problems together.

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