I. The Health Services Workforce

** As stated previously, health services organizations, like most other types of service-based organizations, are highly labor intensive, with approximately 60-70% of the HSO's resources devoted to maintaining an adequate and competent workforce.

** Approximately 60-70% of a given HSO's workforce is comprised of what is collectively referred to as professional staff, who are directly involved in the delivery of health services to patients.

** The remaining 30-40% of a given HSO's workforce is comprised of what is collectively referred to as non-professional (occupational) staff, who primarily serve in a supporting-type role to the professional staff (aides, assistants, clerical/administrative support).

** Professional staff differs, quite obviously, from non-professional staff in a number of ways, many of which are important from an HR perspective:

<table>
<thead>
<tr>
<th>Professional Staff</th>
<th>Non-Professional Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highly specialized training/education/skills</td>
<td>High level of specialization not required</td>
</tr>
<tr>
<td>High level of autonomy</td>
<td>Low level of autonomy</td>
</tr>
<tr>
<td>High level of authority/responsibility</td>
<td>Low level of authority/responsibility</td>
</tr>
<tr>
<td>Most often salaried employees (exempt employees)</td>
<td>Most often hourly workers (non-exempt)</td>
</tr>
<tr>
<td>Functional/theoretical training</td>
<td>Functional training</td>
</tr>
<tr>
<td>Expertise as career goal</td>
<td>Competence as career goal</td>
</tr>
</tbody>
</table>

II. Healthcare Professions

** Examples include physicians (MD, DO), nurses (RN, LPN), dentists (DMD, DDS), pharmacists (RPh, PharmD), optometrists (OD), clinical psychologists (MS, PhD), non-physician practitioners (PA, NP), and allied health professionals including the following: therapy professionals (PT, OT, ST, RRT), technology professionals (MT, RT), social workers (MSW), health educators (various), and dietetic professionals (RD).

** The large majority of these various healthcare professionals work in traditional HSO settings -- hospitals, nursing-related facilities, and physician offices/clinics.
** The growth in the number and types of healthcare professions and professionals over time has been dramatic, especially in the allied health category. Prior to the 1950's, virtually none of the allied health professions were officially recognized as such, and few, if any, persons actually performed these tasks as their sole job responsibility. More typically, such tasks, if completed, were performed by traditional healthcare professionals, especially nurses and/or physicians.

** The impetus for the growth in the numbers and types of healthcare professions and professionals over the last 60 years or so include increased technological sophistication, increased labor specialization, increased third party insurance coverage, an aging population, and rapid increases in the numbers and types of alternate health services delivery sites outside of traditional settings (hospital, MD office).

III. Healthcare Professional Categories and Descriptions

** The Nursing Profession

** Oldest and largest of all healthcare professional categories.

** The origins of nursing as a profession dates back to the middle of the 19th century with the efforts of such legendary figures as Florence Nightingale and Clara Barton.

** Nursing was the first of all healthcare professions to elucidate standards of conduct, practice, and educational preparation -- even prior to the formal of the same in the medical professions.

** Currently, about 2.5 million persons are classified as registered nurses (RN), with the large majority of these working at least part-time in the field, mostly in institutional settings (hospitals and nursing facilities).

** The large majority of registered nurses (85% or more) receive their educational training as part of an undergraduate program of study at a college or university, either at the associate degree level (ADN) or, more commonly, at the baccalaureate level (BSN). A much smaller number of registered nurses receive advanced education/training at the graduate level (more below).

** Complementing RN's in the nursing workforce are approximately 370,000 or so licensed practical nurses (LPN). The vast majority of these also work at least part-time in the field, mostly within institutional facilities as well (especially nursing facilities).
Licensed practical nurses typically receive their functional training at some type of vocational/technical school, where the training emphasis is on developing functional competence as opposed to an emphasis on nursing theory and standards of practice.

All nurses, regardless of designation, must be licensed in their state of practice and must also pass a national competency examination as required under each category. Variations exist from state to state, in terms of scope of practice laws between RN's and LPN's, as to which types of nursing professionals are allowed to do what types of nursing tasks.

Registered nurses at various levels may also become certified in a variety of practice domains (critical care, peri-operative) by completing a formally proscribed program of study and practice in their chosen field of certification. Many institutional HSO's actively sponsor/support such programs to address acute shortages of nursing personnel in designated areas.

A final category of nursing professionals is collectively referred to as advanced practice nurses (APN's). Such professionals are typically masters or doctoral-level prepared registered nurses who have received specialized education/training and/or certification in one of several practice areas. Professionally-recognized ANP's include:

1. *Nurse practitioners (ANP, FNP, PNP)* -- broadest scope of practice of all APN's. Allowed to diagnose, do full patient assessment, and, increasingly, prescribe treatment(s) in an autonomous (or semi-autonomous) fashion.

2. *Certified registered nurse anesthetists (CRNA)* -- most narrow scope of practice of all APN's. Receive education and training in the administration of anesthesia and analgesia in the peri-operative setting under the supervision of a medical anesthesiologist.

3. *Clinical nurse specialists (CNS)* -- scope of practice typically restricted to a specific clinical service line (oncology, diabetes, etc.), with emphasis on patient education, research, and training. Not as autonomous as nurse practitioners.
The Pharmacy Profession

The function of preparing and dispensing "medicinal agents" is as old as written history. As a formal profession, pharmacy evolved during the early 20th century with the advent of federal food and drug laws and the professionalization of medical education during this period of time as well.

Historically, pharmacy as a profession focused on the traditional preparation and dispensing roles. Over time, the emphasis of pharmacy education and practice has evolved into a more patient-centered orientation, with pharmacists assuming the logical role of drug therapy experts in patient populations.

Much like other healthcare professions, pharmacy professionals must receive increasingly specialized education and training in the pharmaceutical and biomedical sciences, must be licensed in their state of practice, and increasingly turn to certification in one of several specialty areas to formalize expertise.

Allied Health Professions

As per the definition from the U.S. Public Health Service, an allied health professional is one who shares in the responsibility of the delivery of health care or related services who has not received an MD, DO, RN, OD, DPM, RPh/PharmD, MPH, DC, MHA, PhD, or MSW.

Allied health professionals are typically thought of as providing highly specific health (or related) services, pursuant to an order or recommendation of a physician or other medical professional, that are typically adjunctive in nature to a patient's overall treatment plan.

As a category, allied health professions are easily the most diverse and numerous (Table 2.2) of all the health professions, and currently comprise approximately 40% of the professional healthcare workforce.

All allied health professionals may be broadly classified into two categories based on level of education/expertise and degree of autonomy in practice settings: (1) therapists/technologists, who have the highest level of education/expertise in a given area and exercise the greatest degree of practice autonomy; (2) technicians/assistants who have the least education/expertise and the least amount of clinical autonomy.
** Professional requirements in terms of education, experience, licensure, and/or certification varies substantially across the various allied health disciplines, and such requirements have evolved significantly over time, especially as it relates to the therapist/technologist category.

IV. HRM Issues with Healthcare Professionals

** Establishment of job qualifications for healthcare professionals

** What is considered minimal competency for current practice? How is this changing over time?

** What are the implications of changes in professional standards of competency on the HSO -- compensation, professional development, policies/procedures, etc.?

** How does the HSO verify job qualifications -- primary source verification vs. secondary source verification? How are such qualifications monitored/tracked over time to ensure maintenance?

** Educational/training support

** Education/training/development for internal purposes -- technology training, leadership training, CQI training

** Education/training/development for external purposes -- JCAHO, OSHA, ACLS, infection control

** Impaired practitioner issues

** Statutory obligations for HSO to monitor/ensure quality of care

** Establishment of policies and procedures to identify, report, and process impaired healthcare professionals

** Future HRM challenges

** Tight labor markets for many/most healthcare professions

** Increased salary/benefits and opportunities for advancement

** Increased involvement with new student recruitment in collaboration with educational entities

** Increased demand for complementary/alternative medicine services and professionals.

** Increased demand for non-physician practitioners (PA, NP) to facilitate collaborative practice model development.
V. Medical Professionals and HRM

** MD's, DO's, DPM's, DMD's/DDS's.

** One of the most important, if not the most important, issue related to medical professionals and organizational human resources management is the task of facilitating the adaptation/integration of these autonomous professionals within the organizational structure so as to facilitate the achievement of organizations strategic goals and objectives within a rapidly changing environment.

** Why is this important? Physicians most commonly serve in the role as a dual agent, concurrently advocating for themselves and their patients on the one hand (as taught in medical school and reinforced in training experiences), and the health services organizations that they are affiliated with on the other hand.

** Are these dual responsibilities necessarily mutually exclusive? In the current increasingly hostile environment of health services, they are becoming more and more exclusive of one another. For example, under DRG-based reimbursement with Medicare, a hospital provider has an incentive to discharge a patient as soon as feasible, based on patient stability or the availability of a more appropriate locus/site of care. The physician, however, does not face the same set of incentives, nor does the patient, typically speaking.

** In this example, the physician is increasingly put in a position of trying to satisfy two sets of stakeholders who have divergent interests - the hospital that wants to discharge the patient as soon as feasible and themselves/their patients who may want an extra day or two in the hospital based on personal preference.

** The role of HRM as it relates to physician adaptation/integration is to provide the necessary infrastructure so as to more closely align the interests/incentives of physicians with that of the health services organization as a whole, so as to facilitate the achievement of organizational goals and objectives.

** The critical necessity of physician adaptation/integration is predicated on the position that physicians and other autonomous medical professionals occupy in the health services marketplace as interface-type stakeholders to the organization that control 80% or more of the resource flows within the HSO. Such stakeholders are characterized as mixed-blessing stakeholders who possess the potential to significantly help OR significantly harm the organization, depending on the issue at hand and the degree to which their interests/incentives are aligned w/the organization.
Further complicating the issue of physician adaptation/integration, as mentioned above, is that the current environment is changing quite rapidly, and most of the changes that are occurring, especially in the areas of reimbursement and antitrust/anti-fraud and abuse law, are having the effect of further differentiating the interests/incentives between independently practicing physicians and health services organizations.

To the extent that the interests/incentives of physicians are significantly different than those of the HSO, to that extent do physicians and other medical professionals have the potential to adversely affect the HSO through their actions and activities.

** Physician Adaptation/Integration Strategies

** HRM Planning/SHRM --

(1) Active facilitation of physician involvement in organizational strategic planning, especially as it relates to major strategic initiatives in clinical areas (new or existing).

(2) Periodic assessment of medical staff attitudes along a variety of conceptual dimensions (job satisfaction, satisfaction with management communications, level of organizational commitment, stress/burnout potential, etc.)

(3) Periodic assessment of level of physician integration by establishing working relationship (employee vs. contractor) and the extent of alignment of interests/incentives (risk sharing arrangements - as allowed by law - level of physician participation in organizational affairs, and participation in organizationally-sponsored training in business-related issues.

** HRM Infrastructure --

(1) Recruitment and selection of physicians for medical staff privileges based on an expanding list of clinical and non-clinical criteria (business, CQI orientation, collaborative-care orientation)
Historically, physicians were not directly included as part of the HSO's performance evaluation process as were other healthcare professions, outside of the traditional credentialing process. This has changed somewhat with the advent of managed care and increased HSO competition. In the evolving system of health services delivery, physician performance assessment is increasingly being incorporated in HSO's as part of an organization-wide performance improvement focus. Providing performance data to physicians in a non-threatening manner, under the auspices of organizational performance improvement, can be used to more closely align interests/incentives.

The role of physician compensation and risk sharing as it relates to the alignment of interests/incentives between physicians and HSO's is complex and controversial due to the dual agent concept elucidated previously. Theoretically, interests/incentives should be more closely aligned when both the HSO and physicians face the same set of resource constraints and/or share some/all of the risk (service/financial) and/or reward (financial) associated with the delivery of health services. The role of HRM in this case is not as straightforward, and only applies to those physicians that are directly employed (and compensated) by the HSO.

The role of HRM in the provision of physician training and development programs that facilitate the adaptation/integration of physicians within the HSO is logical and straightforward under a SHRM approach. The implementation of cross-disciplinary training and development across all health professionals is an emerging phenomenon.

The increasingly important role of HRM in the management of labor relations with physicians is prompted by the recent decision by organized medicine (AMA) to recommend the pursuit of unionization among employed physicians and residents and to petition the federal government to relax anti-trust laws to allow limited unionization/collective bargaining rights to non-employee physicians (independent contractors). A number of mechanisms (HRM and otherwise) exist to address this issue at the organizational level.
**HMR Management of Employee Contribution --**

(1) Understanding the dilemmas that physicians face on a daily basis (double agency issue) and providing support mechanisms to assist them with the management of said dilemmas is an evolving and legitimate HRM function.

(2) Providing/facilitating educational resources that assist in physician adaptation/integration, as described before.

(3) Establishing an organizational culture and structure that is supportive of physicians and other healthcare professionals (policies and procedures to reinforce clinical autonomy of professional staff) within a general context of organizational/professional oversight.

**Management of Organizational Transformation/Change --**

**As mentioned above, change is occurring at a rapid pace in health services delivery, and most of those changes are having (or potentially have) adverse consequences vis-à-vis physician/organizational integration/adaptation.**

**Physicians, like most other humans, are relatively risk-averse in their preferences and behaviors, and thus would almost always prefer certainty (status quo) to uncertainty (change), especially where such changes have the potential to significantly affect their livelihood.**

**According to Ulrich, three different categories of change - initiative, process, and cultural - require HRM involvement to facilitate the adaptation of professional staff to such changes.**

**As it applies to initiative/process organizational change, Ulrich further identified a seven-step process (Fig. 3.3) that allows for HRM facilitation of professional/physician adaptation to change.**

**Step one in the process requires change leadership, ideally from both management and the medical staff, especially as it relates to clinical change issues. Both types of leaders must have sufficient power and influence to "sell" the need for and the type of change required.**
** Step two involves creating a shared need for change among physicians, which is especially challenging given the diversity of interests represented among different physicians. Change efforts should ideally focus their energies in areas where shared needs are greatest.

** Step three involves the creation of a change vision - i.e. where do we want the change(s) to lead us as an organization/group? Accomplishing step three implicitly requires that step four in the process - motivating key stakeholders to embrace change - has been accomplished beforehand. Such stakeholders include physicians (obviously) as well as other non-physician professionals.

** Step five involves changing organizational systems and structures to support the change vision as articulated. Requires maximum organizational flexibility to adapt to the required structural/system changes.

** Step six requires continuous monitoring of the change process as it proceeds, consistent with a CQI/PI approach. Continuous advocacy by management/medical staff as it relates to the change initiative is imperative during change implementation.

** Step seven involves continuous support of successful change management efforts, so as to make such changes (and the results derived therefrom) permanent and prevent "slippage" or relapse to status quo.

** Management of organizational cultural change, per Ulrich, proceeds similarly to the process of managing initiative or process change. Due to the broad and pervasive nature of cultural issues within an organization, however, cultural change initiatives must necessarily involve ALL members of the organization and not just physicians and managers.