A New Starting Point for Workforce Planning

• Cheat Sheets of Emerging Roles to Consider at Your Institution
• Targeted Discussion Guides to Uncover the Right Staffing Strategy for Key Areas
• Templates for Weighing Your Organization’s Future Care Models and Staffing Needs
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The HR Investment Center would like to express its deep gratitude to the individuals and organizations that shared their insights, analysis, and time with us. The research team would especially like to recognize the following individuals for being particularly generous with their time and expertise.

### With Sincere Appreciation

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<th>City, State</th>
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</thead>
<tbody>
<tr>
<td>Advantage Health Physician Network</td>
<td>Grand Rapids, MI</td>
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<tr>
<td>The William W. Backus Hospital</td>
<td>Norwich, CT</td>
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</tbody>
</table>
Executive Summary

Workforce Planning Not Keeping Pace with Care Transformation
Hospitals and health systems are increasingly at risk of trying to meet tomorrow’s challenges with yesterday’s workforce. Industry-wide efforts to transform care delivery will fundamentally alter the type and number of staff organizations need. Yet, compared to the focus on perfecting overall care transformation strategy, leaders have placed much less emphasis on the corresponding workforce planning. And organizations that do not adapt their workforce blueprint now risk being caught off-guard, lacking the type and number of staff they need to deliver care in new ways and succeed in value-based care.

Accounting for Care Transformation in Your Staffing Blueprint
To help HR leaders and business partners craft a staffing blueprint that reflects industry transformation, the HR Investment Center recommends a new starting point in workforce planning. To accurately identify future workforce needs, HR must first work with operational leaders to identify the staff they will need in a new environment. Rather than broadly discussing care transformation and trying to fully quantify new care models—a step most operational leaders are not ready to take—HR can learn 80% of the information it needs by focusing the conversation on four specific market disruptions: increased importance of patient transitions, rising patient complexity, evolving health care technology, and internal executive staffing imperatives.

Focusing the Conversation on Four Key Market Disruptions
Despite the many other changes currently occurring in the market, we recommend focusing most of HR’s effort on these disruptions for three key reasons. First, these four disruptions will drive the vast majority of impact to the staffing blueprint, while other market changes may impact staffing only marginally or not at all. Second, these four disruptions are universal across the industry, and all leaders in all markets must address them. Finally, these disruptions are highly concrete and will be easier for operational leaders to provide information on, ensuring HR obtains the details it needs.

Read the Study in Full to Learn More
A New Starting Point for Workforce Planning offers 13 tools to help HR leaders and business partners hold effective, concrete conversations with operational leaders and extract the necessary staffing information to adjust for each market disruption.
Defining a New Starting Point
for Workforce Planning
A Troubling Divide

*Workforce Planning Not Keeping Pace with Care Transformation*

Hospitals and health systems are increasingly at risk of trying to meet tomorrow’s challenges with yesterday’s workforce. Industry-wide efforts to transform care delivery will fundamentally alter the type and number of staff organizations need. Yet, compared to the focus on perfecting overall care transformation strategy, leaders have placed much less emphasis on the corresponding workforce planning. Organizations that do not adapt their workforce blueprint now risk being caught off-guard, lacking the type and number of staff they need to deliver care in new ways and succeed in value-based care.

In particular, there must be a new starting point in workforce planning. HR leaders can no longer simply project hiring need based on current staffing levels and past turnover. This method assumes future staffing needs will largely mirror current staffing needs—a reasonable assumption in past years, but no longer valid given rapidly evolving care models. Instead, HR leaders must first calculate the impact of new care models on staffing needs and incorporate this into their staffing blueprint.

This report provides HR leaders and business partners resources and tools to execute this new first step. Accompanying HR Investment Center resources for the subsequent steps are also shown here.

Accounting for Care Transformation in Your Staffing Blueprint

*Building the Right Workforce*

**Key Steps:**

1. **Calculate New Care Models**
2. **Project Hiring Need**
3. **Source the Right Candidates**

**HR Investment Center Resources:**

- Transforming the Workforce Blueprint
- The Workforce Demand Forecaster
- Behavioral-Based Interviewing

Source: HR Investment Center interviews and analysis.
Struggling to Get Beyond the Theory

HR Asks…

- How many respiratory therapists will you need?
- How many nurses will you need?

...And Operational Leaders Respond

- I need an interdisciplinary team where everyone works at the top of their license.
- My team needs to be structured to be more cost-effective and hit our productivity metrics.

Gathering the information needed to execute this first step can be more difficult and complex than anticipated. Operational leaders too often discuss care models at a high level, and HR can struggle to extract the level of detail needed to build a workforce blueprint.

It is understandable that operational leaders are not ready to specify their precise future staffing needs while their organization’s overall strategy remains in flux. In fact, many operational leaders are still struggling to resolve larger strategic questions around care delivery and new care settings. An example of this uncertainty is shown in the graphic.

However, this indecision will have negative downstream consequences. As operational leaders work to resolve these larger strategic questions, they continue to postpone critical staffing decisions and risk maintaining an outdated workforce incapable of meeting new industry demands. Therefore, HR must help operational leaders by triggering some early staffing decisions.

Operational Leaders Uncertain What the Future Holds

VP of Cardiology

Potential Service Line Strategies

Expand Patient Access
- Develop live consult telehealth program
- Open satellite office
- Establish urgent care centers

Promote Comprehensive, Multidisciplinary Care
- Centralize subspecialty services
- Partner with ambulatory specialty clinics

Focus on Prevention, Right Size Utilization
- Develop preferred referral network
- Offer group wellness appointments

Source: HR Investment Center interviews and analysis.
To help trigger critical staffing decisions, HR must focus operational leaders on concrete organizational changes and their impact on staffing needs. Rather than broadly discussing care transformation and trying to fully quantify new care models—a step most operational leaders are not ready to take—HR can learn 80% of the information it needs to build a future staffing blueprint by focusing the conversation on the four specific market disruptions shown here.

Despite the many other changes currently occurring in the market, we recommend focusing the majority of HR’s effort on these disruptions for three key reasons.

First, these four disruptions will drive the vast majority of impact to the staffing blueprint, while other market changes may impact staffing only marginally or not at all.

Second, these four disruptions are universal across the industry, and all leaders must address the staffing impact of each irrespective of unique local market factors.

Finally, these disruptions are highly concrete and will be easier for operational leaders to provide information on, ensuring HR obtains the details it needs.

**Focusing the Conversation**

*The Staffing 80/20 of Industry Transformation*

- **I. Increased Importance of Patient Transitions**
- **II. Rising Patient Complexity**
- **III. Rapidly Evolving Health Care Technology**
- **IV. Internal Executive Staffing Imperatives**

Source: HR Investment Center interviews and analysis.
To assist HR in holding effective, concrete conversations with operational leaders, the remainder of this report contains three different types of tools. These tools are designed to be used by HR leaders and business partners to help them extract the necessary staffing information for each market disruption. This information can then be used by HR leaders to proactively adjust future staffing plans and ensure the organization is positioned to overcome each market disruption. An overview of each type of tool is given here. Each tool is accompanied by detailed instructions and blank templates to capture information, where appropriate.

### Arming HR with Three Types of Tools

#### Types of Resources Provided in Toolkit

<table>
<thead>
<tr>
<th>Cheat Sheets</th>
<th>Discussion Guides</th>
<th>Worksheets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easy-to-scan summaries containing critical background information on national trends and their potential staffing impact</td>
<td>Targeted lists of questions equipping HR leaders to surface actionable staffing information from operational leaders</td>
<td>Templates to assist HR leaders in capturing and evaluating the most pertinent information from operational leaders</td>
</tr>
</tbody>
</table>

Source: HR Investment Center interviews and analysis.
A New Starting Point for Workforce Planning

To help HR leaders and business partners craft a staffing blueprint that reflects industry transformation, the HR Investment Center recommends a new starting point for workforce planning. HR leaders can no longer simply project hiring need based on current staffing levels and past turnover. Instead, HR must first calculate the impact of new care models on staffing needs and factor this into their future staffing blueprint. However, operational leaders too often discuss care models at a high level, and HR can struggle to extract the necessary level of detail. Therefore, HR must focus operational leaders on concrete organizational changes and their impact on staffing need. In particular, HR can learn 80% of the information it needs to build a future workforce blueprint by focusing conversations with operational leaders on four specific market disruptions that will drive the vast majority of impact to the staffing blueprint.

The flowchart below represents these 4 market disruptions and 13 associated tools to help HR leaders and business partners hold effective, concrete conversations with operational leaders and extract the necessary staffing information to adjust for each market disruption.

Source: HR Investment Center interviews and analysis.
Section I: Increased Importance of Patient Transitions

Surface Duplicative Transition Management Efforts

Rationale

Improving patient transitions has always been a priority for increasing care quality, but it is increasingly important to financial success following reimbursement changes. For example, two-thirds of hospitals received a readmissions penalty between 2008 and 2011, with the average penalty costing organizations $125,000. In addition to reducing readmissions, patient transitions also directly link to several important quality measures important to P4P payments and Shared Savings bonuses.

However, transition management is too often siloed and not well coordinated. Many department-level pilots for improving transitions, while promising, may be duplicative of other programs in the same organization. This should be particularly alarming to HR leaders, who have worked diligently across the last decade to reduce administrative excess to ensure sufficient bedside resources. Unless HR leaders work to uncover overlapping transitions efforts, they risk wasting resources to fund multiple staff doing the same work.

Primary HR Objective

To account for the impact of the increased importance of patient transitions on care model and clinical staffing, it is critical for HR to identify duplicative transition efforts across the organization and redirect scarce staffing resources.

To do so, HR must first understand the most common transition programs and roles. Second, HR must work with individual operational leaders to build a detailed inventory of all existing (and planned) transition programs. Finally, HR should use this information to create a map of all duplicative transition programs within their organization. The tools in this section will help HR leaders and business partners with each of these steps.

Tools Overview

<table>
<thead>
<tr>
<th>Tool</th>
<th>Intended Users</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool #1: Cheat Sheet for Common Transition Roles</td>
<td>HR business partner</td>
<td>Better understanding of most common transition roles</td>
</tr>
<tr>
<td>Tool #2: Cheat Sheet for Common Transition Programs</td>
<td>HR business partner</td>
<td>Better understanding of most common transition programs</td>
</tr>
<tr>
<td>Tool #3: Discussion Guide for Identifying Organization Transition Efforts and Their Owners</td>
<td>HR executive</td>
<td>List of transition efforts in the organization, and their owners, for HR business partners to use as follow-up contacts for more detailed conversations</td>
</tr>
<tr>
<td>Tool #4: Discussion Guide for Uncovering Details of Current and Planned Transition Efforts</td>
<td>HR business partner</td>
<td>Detailed inventory of all transition efforts in the organization, including patient populations served, roles and job titles involved, and program goals</td>
</tr>
<tr>
<td>Tool #5: Worksheet for Surfacing Duplicative Transition Efforts Across the Organization</td>
<td>HR executive, HR business partner</td>
<td>Mapping of all duplicative transition efforts across the organization</td>
</tr>
</tbody>
</table>

Source: HR Investment Center interviews and analysis.
Section I: Increased Importance of Patient Transitions
Surface Duplicative Transition Management Efforts

How to Use These Tools

**HR Executives:** While optional for HR executives, Tool #1 and Tool #2 provide a quick refresher on the transition roles and programs that may surface during conversations with peer executives. Tool #3 helps HR executives identify care areas with existing (or planned) transition initiatives, so HR business partners can follow up with relevant leaders. Tool #5 enables HR executives to quickly scan the key takeaways of their business partners’ conversations with leaders across the system and identify potentially duplicative transition efforts.

**HR Business Partners:** Tool #1 and Tool #2 provide a quick orientation to the roles and programs that may surface during conversations with operational leaders. Tool #4 helps pinpoint the specific initiatives a unit or care setting is pursuing to improve transitions. Tool #5 provides a quick and easy way to capture detailed notes from conversations with operational leaders (guided by Tool #4).
## Tool #1: Cheat Sheet for Common Transition Roles

**Recommended User:** HR business partners.

**Goal:** Better understanding of most common transition roles.

**Recommended Use:** Use the table below to familiarize yourself with common transition roles before you speak with operational leaders about their strategies to improve care transitions.

**Recommended Preparation:** None.

**Additional Resources:** None.

**Estimated Time Required:** Approximately 20 minutes.

<table>
<thead>
<tr>
<th>Role</th>
<th>Key Responsibilities</th>
<th>Location Within Organization</th>
<th>Number Needed</th>
<th>Background Requirements</th>
</tr>
</thead>
</table>
| **High-Risk Care Manager**    | Help individual patients navigate the system by scheduling appointments (and ensuring patients attend), and helping patients understand their care needs. | Most likely to be found in the nursing department. If these roles are being newly created, they may also be filled by volunteers from the community or from nearby nursing or medical schools. | The number of high-risk care managers needed will depend on the size of the patient population they serve. This service should be provided only to the neediest patients and those with a direct impact on the system’s bottom line. Note: Currently, this role may operate at a loss. Before investing in this role (with anyone other than volunteers) it is essential to understand the timing of the organization’s transition to reimbursement contracts that will reward demand destruction. | While volunteers can help patients navigate the system, if you are hiring FTEs to fill these roles, the following experience is strongly recommended:  
  - Highly experienced RN (>10 years)  
  - Detailed knowledge and understanding of disease processes and the health care system  
  - Willingness and ability to provide psychosocial support to patients who may not be compliant or informed about their health  
  - Excellent communication and patient education skills |
| **System-Wide Transition Management Director** | Coordinate all current projects aimed at improving care transitions, and eliminate waste and duplication. This role is not patient-facing. | Should be placed in executive leadership team, or senior leadership group. | This is the senior-most transition owner. Only one should be hired. | • Health care experience (background as a clinician is ideal but not required)  
  • Excellent communications, project management, and leadership skills  
  • Executive-level experience, mostly to lend credibility to the role, but also to understand the politics associated with executive decision making |

**Other titles include:** Care Coordinator, Care Manager, High-Risk Case Manager, Care Navigator, Health Coach

Source: HR Investment Center interviews and analysis.
## Tool #1: Cheat Sheet for Common Transition Roles (cont.)

<table>
<thead>
<tr>
<th>Role</th>
<th>Key Responsibilities</th>
<th>Location Within Organization</th>
<th>Number Needed</th>
<th>Background Requirements</th>
</tr>
</thead>
</table>
| Cross-Continuum Service Line Director | Manage care coordination and transition efforts within a single service line across all settings. This role is not patient-facing. | Most likely to be found among nursing leadership or service line leadership (depending on organizational structure). | This role could be filled by expanding a current service line director’s responsibilities. If a new hire is needed, only one Cross-Continuum Service Line Director is recommended per service line. | • Clinical or patient care background; RN not required  
• Excellent communication and organization skills  
• A solid understanding of patients’ transition points and care needs across settings |
| **Other titles include:** Service Line Manager |                                                                                        |                                                                                                 |                                                                                                                        |                                                                                                         |
| Inpatient Discharge Coordinator     | Help individual patients prepare for discharge. This includes ensuring patients have access to necessary medications and devices, and caregivers agree on discharge date and instructions. | When this is a dedicated role, it is most often found in nursing, social work, or utilization review.  
*Note: Bedside nurses commonly perform discharge education but often lack time to dedicate to intensive discharge support.* | Scale to number of patients needing services. Fewer are needed than transition coaches, because the provided services are less intensive and shorter-lived. | • RN or social worker  
• Knowledge of disease processes, patient needs after discharge, and available post-discharge care settings and sites  
• Excellent communication skills                                                                                   |
| **Other titles include:** Discharge Coach, RN |                                                                                        |                                                                                                 |                                                                                                                        |                                                                                                         |
| Post-Discharge Medication Auditor   | Offer post-discharge medication reconciliation, usually by phone.                      | Most likely to be found in nursing or pharmacy.                                                 | Scale to number of patients needing services.                                                                         | • RN, pharmacist, or pharmacy tech  
• Experience working directly with patients and families  
• Excellent communication skills  
• Detailed knowledge of medication interactions                                                                                        |
### Tool #1: Cheat Sheet for Common Transition Roles (cont.)

<table>
<thead>
<tr>
<th>Role</th>
<th>Key Responsibilities</th>
<th>Location Within Organization</th>
<th>Number Needed</th>
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</tr>
</thead>
</table>
| **Post-Acute Care Facility Liaison**      | Oversee care transitions **between the inpatient setting and specific post-acute care facilities**, and ensure post-acute care facility quality. | Most likely to be found within the nursing department (either inpatient or associated with a specific post-acute care facility). | Scale to desired number of post-acute care facilities. | • Clinical or patient care background  
• Excellent communication and organization skills  
• A solid understanding of the capabilities of post-acute facilities |
| **Other titles:** Post-Acute Care Coordinator, Post-Acute Care Manager |                                                                                     |                                                                                               |                                                                               |                                                                                          |
| **Community Resource Specialist**         | Help patients **connect with resources within the community to support patients’ transition home**, including help managing chronic conditions. | Can often be filled by community volunteers or social workers.                                 | Scale to number of patients needing services. Fewer are needed than transition coaches, because the provided services are less intensive and shorter-lived. | • Clinical, patient care, or social work background preferred but not required  
• Knowledge of patients’ medical and psychosocial post-acute care needs, along with available resources  
• Excellent communication skills and ability to collaborate with community resources |
| **Other titles:** Community Health Worker, Health Coach |                                                                                     |                                                                                               |                                                                               |                                                                                          |

Source: HR Investment Center interviews and analysis.
### Tool #2: Cheat Sheet for Common Transition Programs

**Recommended User:** HR business partners.

**Goal:** Better understanding of most common transition programs.

**Recommended Use:** Use the table below to familiarize yourself with common transition programs before you speak with operational leaders about their strategies to improve care transitions.

**Recommended Preparation:** None.

**Additional Resources:** None.

**Estimated Time Required:** Approximately 15 minutes.

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Capsule Description</th>
<th>Source/Sponsor</th>
<th>Key Interventions</th>
</tr>
</thead>
</table>
| Care Transitions Intervention  | Four-week program targeting a specific patient population age 65 or older. This program is primarily focused on teaching patients self-management skills. | University of Colorado Health Science Center, Dr. Eric Coleman | • Medication self-management  
• Timely follow-up |
| Project Re-Engineered Discharge (RED) | Research program that develops and tests strategies to improve the hospital discharge process to promote patient safety and reduce re-hospitalization rates. | Boston University Medical Center | • Medication reconciliation  
• Discharge plan reconciliation  
• Follow-up appointment scheduling  
• Outstanding test follow-up  
• Patient education of red flags  
• Discharge summary sent to PCP  
• Follow-up call within 72 hours |
| Transitional Care Model        | Provides comprehensive in-hospital planning and home follow-up for chronically ill, high-risk older adults hospitalized for common medical and surgical conditions. The model revolves around the Transitional Care Nurse, who follows patients from hospital to home. | University of Pennsylvania, Mary Naylor             | • Transitional Care Nurse provides patient support for two months (via home visits, phone check-ins, and in-person attendance at first follow-up visit)  
• Patient and family engagement  
• Early identification and response to health risks  
• Multidisciplinary care |

Source: HR Investment Center interviews and analysis.
### Tool #2: Cheat Sheet for Common Transition Programs (cont.)

<table>
<thead>
<tr>
<th>Program Title</th>
<th>Capsule Description</th>
<th>Source/Sponsor</th>
<th>Key Interventions</th>
</tr>
</thead>
</table>
| Project BOOST (Better Outcomes for Older Adults Through Safe Transitions) | National initiative broadly intended to **improve the care of patients as they transition from hospital to home**, both by identifying high-risk patients on admission and targeting risk-specific interventions and by implementing strategies to reduce 30-day readmission rates for general medicine patients. | Society of Hospital Medicine             | • Patient risk stratification  
• Medication reconciliation  
• Discharge education and teach-back  
• Patient-friendly discharge summary  
• Discharge communication with post-acute providers  
• Direct communication with principal outpatient provider at discharge  
• Follow-up call within 72 hours |
| Hospital to Home (H2H)                                   | National quality improvement campaign to **reduce cardiovascular-related hospital readmissions** and improve the transition from inpatient to outpatient status for patients hospitalized with cardiovascular disease via sharing of evidence-based best practices. | IHI and the American College of Cardiology | • Follow-up visit scheduled within one week of discharge  
• Medication management  
• Patient education to help patients understand early warning signs of deterioration  
• Patient activation in self-management |

Source: HR Investment Center interviews and analysis.
# Tool #3: Discussion Guide for Identifying Organization Transition Efforts and Their Owners

**Recommended User:** HR executive.

**Goal:** List of transition efforts in the organization, and their owners, for HR business partners to use as follow-up contacts for more detailed conversations.

**Recommended Interviewee:** Clinical executives with oversight of care transitions such as chief nursing officers and chief medical officers.

**Recommended Preparation:** None.

**Additional Resources:** None.

**Estimated Time Required:** Approximately 45 minutes per executive. Multiple interviews may be required if multiple executives have direct oversight over care transitions.

**Abbreviated Guide:** If pressed for time, focus on questions in bold. These questions should take approximately 15 minutes.

**Available Online:** The discussion guide is presented below, with notes that will help you lead the conversation. To access an editable version of the guide, please visit our website at advisory.com/hric/workforceplanning.

## Discussion Questions

### 1. Do you currently oversee any organization-wide transition management efforts?

**If so:**
- a. What patients and/or specific transitions do these efforts target?
- b. Who owns these efforts?

**If not:**
- a. Would you like to start any organization-wide transition management efforts?
- b. What holds you back?

### 2. Do you currently oversee any service-line or care-area specific transition management efforts?

- a. What do the projects look like?
- b. **Which service lines or care areas are pursuing these efforts?**
- c. **Which directors or managers own these efforts?**
- d. Do you struggle to coordinate all of the existing projects happening across the system?
  - i. Would it be feasible for a single person to coordinate all these transition projects?

## Guidance for Leading the Discussion

- Business partners should follow up with any leaders who are working on transition efforts, participating in transition pilots, or overseeing settings or patient populations that experience high likelihood of readmission.

- Business partners can use Tool #4 to guide their conversations with operational leaders and learn specific information about each leaders’ efforts.

- Adding a new role to oversee transitions is costly and not right answer for every organization, but it can be powerful in consolidating transition efforts.

- Ask questions 2d, i-ii **only if you believe there is (or will soon be) political appetite and sufficient resources to add a new leadership role to coordinate transitions.**

Source: HR Investment Center interviews and analysis.
Tool #3: Discussion Guide for Identifying Organization Transition Efforts and Their Owners (cont.)

### Discussion Questions

ii. If a single person oversaw all transitions, would you give this responsibility to someone in an existing role? Or would you prefer to create a new, wholly dedicated role?

3. Are you planning to implement any new initiatives to improve care transitions in the coming year?
   - a. At what level: organizational, service line, or unit?
   - b. Who do you plan to have oversee these new initiatives?

### Targeting Care Transition Efforts

4. Do you have any particularly strong working partnerships with specific post-acute care providers?

5. Does our system see unusually high readmission rates from any specific post-acute care facilities?
   - a. If so, which post-acute care facilities?
   - b. Are you considering any pilots to improve transitions to these providers?
     - i. Who would manage these pilots?
     - ii. What would your timeline be?

6. Does our system struggle with potentially avoidable readmissions from any specific patient populations?
   - a. Which patient populations?
   - b. Are you considering any pilots to improve transitions for these patients?
     - i. Who would manage these pilots?
     - ii. What would your timeline be?

7. Do you have agreements with payers that incentivize better transition management for any specific patient populations?

8. Overall, would you say that you struggle more with the transitions of specific patient groups or to specific post-acute care facilities?

### Guidance for Leading the Discussion

These questions lay the groundwork for helping executives select a system-level transition strategy after duplication has been surfaced. The two primary transition strategies are: (1) focusing on the riskiest transition or (2) focusing on the riskiest patients.

It is helpful to ask these questions now, because they may also surface specific operational leaders with whom to follow up to learn more about individual projects.

Source: HR Investment Center interviews and analysis.
Tool #4: Discussion Guide for Uncovering Details of Current and Planned Transition Efforts

**Recommended User:** HR business partners.

**Goal:** Detailed inventory of all transition efforts in the organization, including patient populations served, roles and job titles involved, and program goals.

**Recommended Interviewee:** Manager- or director-level operational leaders with oversight of care transitions or care transitions initiatives. A prior interview with executive-level leaders will help you identify who to speak with. If following up with multiple operational leaders, speak with each leader individually.

**Recommended Preparation:** None.

**Additional Resources:** (Optional) Bring Tool #5: Surfacing Duplicative Transition Efforts Across the Organization to facilitate note-taking.

**Estimated Time Required:** Approximately one hour per leader. If a director or manager owns an especially large number of transition projects, or the projects are especially detailed, an additional follow-up session may be needed.

**Available Online:** The discussion guide is presented below, with notes that will help you lead the conversation. To access an editable version of the guide, please visit our website at advisory.com/hric/workforceplanning.

---

**Discussion Questions**

1. Do you see especially high rates of readmissions for any particular patient group?
2. Do you see patients being readmitted particularly often from any specific facilities or settings?
3. Do you have plans to work on any projects to improve care transitions in the coming year?

**For each project:**

a. What is your timeframe?

b. Is the project homegrown?
   i. If not, is it a widely used program?
   ii. Are you working with any other organizations or payers on this program?

c. What is the name of the project?

d. What patients does the program serve (e.g., diabetes patients, pediatric patients with psycho-social needs, etc.)?

e. What transitions does it support (e.g., from inpatient to a post-acute facility, or from rehab to home)?

---

**Guidance for Leading the Discussion**

For each project the operational leader lists, ask all of the following questions. The goal of these questions is to learn as much as possible about existing transition roles and programs within this operational leader's purview. If desired, use Tool #5 to document each project and the responsibilities of each care team member.

There are a variety of widely used, titled programs aimed at improving transitions. It is important to ask if operational leaders are utilizing one of these programs, because widely used programs have less flexibility in staffing than similar homegrown programs. For a list of widely used programs, see Tool #2.

---

Source: HR Investment Center interviews and analysis..
Tool #4: Discussion Guide for Uncovering Details of Current and Planned Transition Efforts (cont.)

Discussion Questions

For each project (cont.):

f. How many members of your staff are involved on the project?

g. What are their job titles?

h. What are their main responsibilities as part of the project?

i. Do you have a sufficient number of staff to take care of all needed responsibilities of the project?
   i. If not, who are you missing?

j. Are you working with any other units or leaders on this project?
   i. If so, who is leading the project?

Guidance for Leading the Discussion

For each project the operational leader lists, ask all of the following questions. The goal of these questions is to learn as much as possible about existing transition roles and programs within this operational leader’s purview. If desired, use Tool #5 to document each project and the responsibilities of each care team member.

It is important to obtain as much detail as possible. When organizational leaders look for duplication across transition projects, they will look closely at each staff member’s responsibilities. You should press operational leaders to provide specific details. Examples of specific responsibilities care team members may be performing are:

- Inpatient medication education
- Inpatient self-care education
- Inpatient evaluation of post-discharge psychosocial support
- Inpatient assistance acquiring needed devices or equipment
- Post-discharge patient satisfaction phone call
- Post-discharge medication reconciliation phone call
- Patient appointment scheduling
- Attendance at patient follow-up appointments
- Setting-to-setting patient handoff (by phone)
- Cross-setting EMR maintenance
- Insurance preauthorization for transfer to a different care setting
- Post-acute care provider quality assessment

Source: HR Investment Center interviews and analysis.
# Tool #5: Worksheet for Surfacing Duplicative Transition Efforts Across the Organization

**Recommended User:** HR business partners and HR executives.

**Goal:** Mapping of all duplicative transition efforts across the organization.

**Recommended Use for business partners:** After speaking with operational leaders (using Tool #4 to structure your conversations), use your notes from all interviews to fill out the table that follows. List one transition project or role per row.

Then scan the table to see if the operational leaders you spoke with have different people performing similar work or are pursuing overlapping projects. You may want to start by focusing on the patient population served by each project and the key responsibilities performed.

It may be helpful to highlight similar responsibilities or patient groups on the table, in order to more easily see duplication. Once the table is complete, return it to your HR executive along with your observations on duplicative efforts.

**Recommended Use for HR Executives:** After gathering all Business Partner’s notes, scan the table to see if your organization is pursuing duplicative transition efforts.

**Estimated Time Required for HR business partners:** Approximately one hour.

**Estimated Time Required for HR Executives:** Approximately one hour.

**Recommended Preparation:** HR business partners will need to speak with operational leaders to populate the table. Business partners can use Tool #4 to structure the conversation.

<table>
<thead>
<tr>
<th>Patient Population Served</th>
<th>Key Responsibilities Performed</th>
<th>Similar Responsibilities Highlighted</th>
<th>Observations on Duplicative Efforts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

*Source: HR Investment Center interviews and analysis.*
Tool #5: Worksheet for Surfacing Duplicative Transition Efforts Across the Organization (cont.)

<table>
<thead>
<tr>
<th>Project/Role Name</th>
<th>Department</th>
<th>Owner/Project Lead</th>
<th>Patient Population Served</th>
<th>Time Spent¹</th>
<th>Key Responsibilities of Project or Role</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

¹) Total number of hours per week spent on project across all FTEs working on the project.

Source: HR Investment Center interviews and analysis.
Section II: Rising Patient Complexity

Facilitate Stop-Start-Delegate Conversations

Rationale

Patient complexity is on the rise in all care settings as the population ages and incidence of chronic conditions increases. Yet, too many organizations continue to answer this challenge by simply adding more staff. This high-cost strategy is clearly unsustainable.

A more sustainable strategy for safely and effectively caring for more complex patients is better leveraging highly skilled clinicians. In other words, ensure all clinical staff practice at “Top-of-License,” allowing highly skilled staff to delegate down lower-skill work so they can focus on the most complex tasks. For example, the average med/surg unit spends $750,000 each year paying registered nurses to complete tasks that could be performed by lower-cost staff or not performed at all.1

However, clinical staff often lack the clarity needed to effectively delegate. Without explicit direction from their operational leaders, highly skilled staff will assume many care tasks with the goal of maintaining quality, including low-skill work such as patient baths. HR must help operational leaders clarify the tasks highly skilled staff should and should not own. Otherwise, organizations risk having the highest-cost staff continue to unnecessarily perform low-skill work.

Primary HR Objective

To account for the impact of increasingly complex patients on care models and clinical staffing, it is critical for HR to trigger “start-stop-delegate” conversations with operational leaders and ensure top-of-license care (and effective delegation) among clinical staff.

To do so, HR should first identify departments considering care team redesign. Second, HR must clarify operational leaders’ perspectives on the best set of responsibilities for each care team member. The tools in this section will help HR leaders and business partners with each of these steps.

Tools Overview

<table>
<thead>
<tr>
<th>Tool</th>
<th>Intended Users</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool #6: Discussion Guide for Identifying Executive Priorities for Top-of-License Practice</td>
<td>HR executive</td>
<td>List of departments with or considering pilots to restructure the care team for HR business partners to use as follow-up contacts for more detailed conversations</td>
</tr>
<tr>
<td>Tool #7: Discussion Guide for Uncovering the Ideal Distribution of Responsibilities Across the Care Team</td>
<td>HR business partner</td>
<td>Detailed allocation of current responsibilities for all care team members, delineating responsibilities they should delegate up, delegate down, or simply stop doing</td>
</tr>
</tbody>
</table>


Source: HR Investment Center interviews and analysis.
Section II: Rising Patient Complexity

Facilitate Stop-Start-Delegate Conversations

How to Use These Tools

**HR Executives:** Tool #6 helps HR executives identify areas with pilots to improve top-of-license practice so business partners can follow up with the relevant leaders.

**HR Business Partners:** Tool #7 helps business partners hold concrete conversations with clinical leaders about the ideal distribution of responsibilities within their care teams.

After business partners conduct these discussions with operational leaders, HR executives should meet with operational leaders working on pilots to discuss strategies for caregiver specialization. To prepare for these meetings, HR executives can quickly come up to speed on existing care team structures by reviewing notes taken by business partners during their conversations with operational leaders (using a notes page included in Tool #7).
Tool #6: Discussion Guide for Identifying Executive Priorities for Top-of-License Practice

**Recommended Interviewer:** HR executive.

**Goal:** List of departments with (or considering) pilots to restructure the care team for HR business partners to use as follow-up contacts for more detailed conversations.

**Recommended Interviewee:** Clinical executives, such as the chief nursing officer, vice presidents of ambulatory care, and chief medical officer. If conducting interviews with multiple clinical executives, speak with each leader individually.

**Recommended Preparation:** None.

**Additional Resources:** None.

**Estimated Time Required:** Approximately 30 minutes per executive.

**Abbreviated Guide:** If pressed for time, focus on questions in bold. This should take approximately 15 minutes.

**Available Online:** The discussion guide is presented below, with notes that will help you lead the conversation. To access an editable version of the guide, please visit our website at advisory.com/hric/workforceplanning.

---

**Discussion Questions**

**Clarifying Plans for Care Team Innovation**

1. Which units or care areas are involved in pilots to innovate care team structure to promote top-of-license practice?

**Determining What to Start, Stop, and Delegate**

2. Are there any responsibilities you would like to add to your care teams' plates (or any you would like to ensure are performed more consistently)?
   
   a. Who would you like to see take on these responsibilities?
   
   b. What responsibilities need to be off-loaded from staff's current workload to give them capacity to take on these new responsibilities?

3. What responsibilities should highly trained staff members delegate down to support staff members?

4. What responsibilities do support staff currently perform that should be passed up to a higher-trained member of the care team?

5. Are there responsibilities your care teams should simply stop doing?

**Guidance for Leading the Discussion**

The goal of Question 1 is to generate a list of operational leaders with whom business partners should conduct follow-up discussions.

Questions 2-5 are the core of the Start-Stop-Delegate conversation. It is important to understand the executive perspective on these questions, but business partners will be able to gain much more specific information through their discussions with managers and directors.

It will be important to understand both perspectives when you later facilitate clinical leader decision making on whether or not to pilot specialized roles within identified care teams.

Source: HR Investment Center interviews and analysis.
Tool #6: Discussion Guide for Identifying Executive Priorities for Top-of-License Practice (cont.)

Discussion Questions

Meeting Rising Patient Complexity

6. Which units (or care settings) do you expect to see the greatest rise in patient complexity?
   a. Which units or settings do you anticipate will not see much, if any, change in complexity?

7. Are the care teams in these areas set up to handle these increasingly complex patients?
   a. If not, in what ways should the staff you need be different than the staff you have now?

Guidance for Leading the Discussion

The questions in this section will help identify "pain points," those areas where patient complexity will be an especially challenging problem.

It is important to map clinical executives’ opinions on which areas may face the greatest challenge with patient acuity with the opinion of operational leaders within those areas. This will help you successfully facilitate conversations on where to pilot specialized roles within care teams.

The goal of Question 6 is to prioritize potential areas of concern. If a leader says all staff will be impacted, ask for his or her top three units or care settings.

Ask Questions 7 and 7a for each area the leader mentions.

Source: HR Investment Center interviews and analysis.
# Tool #7: Discussion Guide for Uncovering the Ideal Distribution of Responsibilities Across the Care Team

**Recommended User:** HR business partners.

**Goal:** Detailed allocation of current responsibilities for all care team members, delineating responsibilities they should delegate up, delegate down, or simply stop doing.

**Recommended Interviewee:** Manager- or director-level operational leaders with oversight of clinical care teams. A prior interview with clinical executives will help HR identify the appropriate managers and directors to interview. If following up with multiple operational leaders, speak with each leader individually.

**Recommended Preparation:** None.

**Additional Resources:** (Optional) Bring a copy of the notes page at the end of this discussion guide to facilitate note taking.

**Estimated Time Required:** Approximately one hour per leader.

**Available Online:** The discussion guide is presented below, with notes that will help you lead the conversation. To access an editable version of the guide, please visit our website at advisory.com/hric/workforceplanning.

## Discussion Questions

### Understanding the Current Care Team Structure

1. What does your current care team structure look like?
   - a. What types of caregivers work in your unit/care area?
   - b. How many of each?

### Determining What to Start, Stop, and Delegate

**For each member of your care team...**

2. Are there any responsibilities you would like this caregiver to **start** doing (or any you would like to ensure are performed more consistently)?

3. What responsibilities should this caregiver **delegate down** to support staff members?

## Guidance for Leading the Discussion

The goal of this section is to gain context for the rest of the conversation and understand the unit’s current staffing. If the operational leader gives answers that are vague or lofty, move on to the next section.

Questions 2, 3, 4, and 5 are the root of the **start-stop-delegate** conversation and are where you should **spend the bulk of the discussion. Ask questions 2-5 for each member of the clinical care team.** A typical inpatient care team will include RNs and nurse aides (PCAs, CNAs, or PCTs). It may also include advanced practitioners (NPs or PAs). These questions should push operational leaders to think about the work on their unit that needs to get done as opposed to the number of staff they have to do the work. **It is important to guide the operational leader to provide specifics when discussing staff responsibilities.**

**Question 2 is the “start” question** and is used to identify new responsibilities that should be taken on by each type of staff member.

**Questions 3-5 are the “delegate” questions** and are used to identify responsibilities that should be off-loaded to others—either passed up, delegated down, or delegated out to other departments.

Source: HR Investment Center interviews and analysis.
Tool #7: Discussion Guide for Uncovering the Ideal Distribution of Responsibilities Across the Care Team (cont.)

Discussion Questions

4. What responsibilities does this caregiver currently perform that should be passed up to a higher-trained member of the care team?
   a. Which caregiver do you think is best positioned, or most qualified, to take on these responsibilities?
   b. What do you think prevents support staff from passing those responsibilities up to the correct caregiver?

5. What responsibilities does this caregiver currently perform that you feel should be delegated out to other departments or teams?
   a. What team or individual would you like to see perform each of those responsibilities?
   b. What do you think prevents this cross-team delegation?

6. What responsibilities does this caregivers currently perform that they should simply stop doing?
   a. What do you think prevents them from stopping these responsibilities entirely? (Is something preventing you from telling them to stop doing these responsibilities, or are they continuing to do it even after you’ve told them to stop?)

Guidance for Leading the Discussion

It may be helpful to provide suggestions of responsibilities that may be able to be off-loaded to support staff, such as patient baths and feeding patients.

Off-loading direct patient care responsibilities from nurses to support staff can be a sensitive topic. Nurses may want to continue to provide these patient care responsibilities for the purpose of patient safety or maintaining a connection with the patient. If nurse leaders are hesitant or uncomfortable with discussing responsibilities to off-load, frame the questions as helping protect RN time to perform work only an RN can do.

Question 6 is the “stop” question and is used to identify responsibilities caregivers can stop performing altogether.
Tool #7: Discussion Guide for Uncovering the Ideal Distribution of Responsibilities Across the Care Team (cont.)

**Discussion Questions**

Planning the Future Care Team Structure

7. Should we change the mix of existing staff member types within your unit or care setting to ensure all work is being done?
   a. What types of staff members do you think you need more of?
   b. Are there any staff member types you think you need fewer of?
   c. Will your plans ultimately change the way patients are allocated to caregivers?
   d. Do you need to add any new types of staff to the team (for example, would you want to add pharmacists to an inpatient nursing unit)?

**Guidance for Leading the Discussion**

These questions are intended to surface whether the manager or director would like to alter his or her unit’s care team skill mix. While responses here do not indicate a need to immediately add a position, the combination of these questions and leaders’ responses to the task allocation questions above should give a complete picture of the unit’s staffing needs.

Source: HR Investment Center interviews and analysis.
### Tool #7: Discussion Guide for Uncovering the Ideal Distribution of Responsibilities Across the Care Team (cont.)

#### Notes Page (Optional)

**Recommended User:** HR business partner.

**Recommended Use:** Use the table below to take notes for Questions 3-6.

<table>
<thead>
<tr>
<th>Care Team Member</th>
<th>Responsibilities to Delegate Down (Question 3)</th>
<th>Adequate Support Staff? (Question 3c)</th>
<th>Responsibilities to Delegate Up (Question 4)</th>
<th>Responsibilities to Stop Doing (Question 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td></td>
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<td></td>
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<tr>
<td>Advanced Practitioner (NP, APN, PA)</td>
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<tr>
<td>RN</td>
<td></td>
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</table>

Source: HR Investment Center interviews and analysis.
Tool #7: Discussion Guide for Uncovering the Ideal Distribution of Responsibilities Across the Care Team (cont.)

Notes Page (Optional)

<table>
<thead>
<tr>
<th>Care Team Member</th>
<th>Responsibilities to Delegate Down (Question 3)</th>
<th>Adequate Support Staff? (Question 3c)</th>
<th>Responsibilities to Delegate Up (Question 4)</th>
<th>Responsibilities to Stop Doing (Question 6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPN/LVN</td>
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<tr>
<td>PCA/MA</td>
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</table>

Source: HR Investment Center interviews and analysis.
Section III: Rapidly Evolving Health Care Technology

Match Staff to EMR and Telehealth Program Goals

Rationale

The last decade has seen an explosion in health care technology, both in type of technology available and investments made by hospitals and health systems. In a recent survey, 79% of health care CEOs said they expect to further increase their investment in technology beyond already unprecedented levels.1

To keep pace with technological advances, HR and operational leaders both must work to quickly identify each piece of technology’s effect on staff. So far, most technology has affected staff workflow more than staffing need. In other words, more impact on how work is done, not who does it.

However, there are two important exceptions—EMR and telehealth/remote monitoring technologies. Full utilization of these two technologies often requires new skills or even new roles. Unless HR helps organizational leaders appropriately adjust staffing along with implementation of these two technologies, organizations risk only partial returns on their multimillion dollar investments.

Primary HR Objective

To account for the impact of rapidly evolving health care technology on staffing need, it is critical that HR identify the organization’s EMR and telehealth goals and ensure staffing resources match those plans.

To do so, HR must first better understand how these two technologies impact staffing need. Second, HR should work with IT leaders to learn the organization’s EMR goals and what new staff skills are needed to support those goals. Finally, HR must determine the types of telehealth programs the organization has or plans to build and any new roles required for those programs. The tools in this section will help HR leaders and business partners with each of these steps.

Tools Overview

<table>
<thead>
<tr>
<th>Tool</th>
<th>Intended Users</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool #8: Cheat Sheet for Assessing Staffing and Workflow Implications of Health Care Technologies</td>
<td>HR business partner</td>
<td>Better understanding of workflow and staffing implications for most common health care technologies</td>
</tr>
<tr>
<td>Tool #9: Discussion Guide for Identifying Staffing Needs to Accomplish Near-Term EMR Goals</td>
<td>HR executive</td>
<td>Detailed analysis of EMR programs by care setting, including current stage of implementation, business intelligence goals, and new staff skills required to execute</td>
</tr>
<tr>
<td>Tool #10: Discussion Guide for Identifying Staffing Needs to Accomplish Telehealth Goals</td>
<td>HR business partner</td>
<td>Detailed analysis of new roles and certifications required for telehealth programs, broken down by administrative, nursing, and clinical support staff</td>
</tr>
</tbody>
</table>

Section III: Rapidly Evolving Health Care Technology
Match Staff to EMR and Telehealth Program Goals

How to Use These Tools

**HR Executives:** While optional, Tool #8 provides a quick refresher on the workflow and staffing implications of different health care technologies. Tool #9 helps HR executives identify IT leaders’ EMR goals and surface associated staffing needs.

**HR Business Partners:** Tool #8 provides a quick orientation to the workflow and staffing implications of different health care technologies. Tool #10 helps HR business partners hold concrete conversations with operational leaders about their telehealth plans and specific telehealth staffing needs.
Tool #8: Cheat Sheet for Assessing Staffing and Workflow Implications of Health Care Technologies

**Recommended User:** HR business partners.

**Goal:** Better understanding of workflow and staffing implications for most common health care technologies.

**Recommended Use:** Use the table below to familiarize yourself with the relative workflow and staffing implications of different technologies before speaking with operational leaders about new technologies they intend to adopt.

**Recommended Preparation:** None.

**Additional Resources:** None.

**Estimated Time Required:** Approximately 15-20 minutes.

### Legend:

- None
- Low
- Medium
- High

<table>
<thead>
<tr>
<th>Technology Category</th>
<th>Technology Description</th>
<th>Common Vendors</th>
<th>Workflow Impact 1</th>
<th>Staffing Impact 1</th>
<th>Key Staffing Insights 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Decision Support Technologies</td>
<td>Interactive software and support systems designed to assist physicians and other health professionals with decision-making (e.g., determining diagnoses or medical courses of action)</td>
<td>• CADUCEUS • DiagnosisPro • Dxplain • MYCIN • RODIA</td>
<td></td>
<td></td>
<td>Will enable the elimination of some waste in workflow but not enough to impact staffing</td>
</tr>
<tr>
<td>Health Information Exchange Technologies</td>
<td>Software that allows the exchange of health information between different systems in a secure, consistent, and accurate way</td>
<td>• Most enterprise vendors (Epic, Cerner, Allscripts, Siemens, McKesson, etc.) • Medicity (Aetna) • Axolotl (OptimumInsight) • dbMotion • Wellogic • Verizon</td>
<td></td>
<td></td>
<td>Will enable the elimination of some waste in workflow, but not enough to impact staffing</td>
</tr>
</tbody>
</table>

1) Scope and magnitude of impact refers to impact on end-users of technology, not IT department staff.
# Tool #8: Cheat Sheet for Assessing Staffing and Workflow Implications of Health Care Technologies (cont.)

<table>
<thead>
<tr>
<th>Technological Innovation</th>
<th>Technology Description</th>
<th>Common Vendors</th>
<th>Workflow Impact¹</th>
<th>Staffing Impact¹</th>
<th>Key Staffing Insights¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Real-Time Locating Technologies</strong></td>
<td>Software with the ability to locate a person or asset</td>
<td>• Awarepoint • Centrak • Innerwireless • Polycom • Radianse • Visonic Technologies</td>
<td>Scope of Impact: [● ● ●]</td>
<td>Magnitude of Impact: [● ● ●]</td>
<td>Representative Workflow Impact: Helps clinicians more easily find what they are looking for. Representative Staffing Impact: Minimal, if any. Will enable the elimination of some waste in workflow but not enough to impact staffing.</td>
</tr>
</tbody>
</table>

| **Administrative Support Technologies** | Automated Staffing Solutions: Systems that use census and acuity data to predict coverage need and help organizations match staff appropriately | Automated Staffing Solutions: • APO • Concerros Online Patient Portals and Appointment Scheduling: • Omedix • Medical Web Experts • Spectrasoft • AdvancedMD | Scope of Impact: [● ● ●] | Magnitude of Impact: [● ● ●] | Representative Workflow Impact: Helps unit managers the ability to more efficiently build schedules and staff an opportunity to electronically manage their hours, leave tracking, etc. Representative Staffing Impact: If staffing is more effectively and reliably matched to census, may reduce need for costly contract labor. Will improve staffing accuracy but is unlikely to change the overall number of hours that people work; may reduce need for schedulers. |

| **Administrative Support Technologies** | Online Patient Appointment Scheduling: Web-based software that streamlines patient interactions through a single interface | | | | |

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¹ Scope and magnitude of impact refers to impact on end-users of technology, not IT department staff. Source: HR Investment Center interviews and analysis.
Tool #8: Cheat Sheet for Assessing Staffing and Workflow Implications of Health Care Technologies (cont.)

<table>
<thead>
<tr>
<th>Technological Innovation</th>
<th>Technology Description</th>
<th>Common Vendors</th>
<th>Workflow Impact$^1$</th>
<th>Staffing Impact$^1$</th>
<th>Key Staffing Insights$^1$</th>
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</thead>
</table>
| Cloud Computing Technologies | Web-based technology that allows an organization to utilize all programs and computer infrastructure through a remote service, rather than keeping its own IT infrastructure on-premise | • Microsoft Azure  
• Google  
• OpenNebula  
• Nimbus  
• IBM SmartCloud | Scope of Impact:  
Magnitude of Impact:  
Representative Workflow Impact: Minimal, if any | Scope of Impact:  
Magnitude of Impact:  
Representative Staffing Impact: Minimal, if any | Will not impact staffing |
| Unified Communication Technologies | Software that integrates telephony, VOIP, SMS, email, data, and video to create a common communication environment | • Avaya  
• Cisco  
• IBM  
• Verizon  
• Microsoft  
• Siemens | Scope of Impact:  
Magnitude of Impact:  
Representative Workflow Impact: Makes information sharing easier by allowing everyone to use their preferred means of communication | Scope of Impact:  
Magnitude of Impact:  
Representative Staffing Impact: Minimal, if any | Potential to streamline communication, but no notable impact on staffing |

$^1$ Scope and magnitude of impact refers to impact on end-users of technology, not IT department staff.

Source: HR Investment Center interviews and analysis.
### Tool #8: Cheat Sheet for Assessing Staffing and Workflow Implications of Health Care Technologies (cont.)

<table>
<thead>
<tr>
<th>Technological Innovation</th>
<th>Technology Description</th>
<th>Common Vendors</th>
<th>Workflow Impact</th>
<th>Staffing Impact</th>
<th>Key Staffing Insights</th>
</tr>
</thead>
</table>
| **Natural Language Processing Technologies** | Software that converts natural speech, text, and terms to medical vocabularies and codes | • M*Modal  
• Nuance  
• IBM  
• CodeRyte  
• CliniThink | Scope of Impact:  
Magnitude of Impact: | Magnitude of Impact: | Will enable the elimination of some waste in workflow and possible reliance on coders, but overall staffing impact minimal |
|  |  |  | Representative Workflow Impact: Streamlines coding and documentation, potentially making it faster and reducing the frequency of mistakes | Representative Staffing Impact: Minimal impact on some administrative staff, including transcriptionists and coders |  |
| **Business Intelligence Technologies** | Software and processes used to distill insights from large stores of clinical and business data. These tools can describe past events, predict the likelihood of future events, and/or prescribe action in specific scenarios | • Avaya  
• Cisco  
• IBM  
• Verizon  
• Microsoft  
• Siemens | Scope of Impact: Too early to assess | Magnitude of Impact: Too early to assess | Workforce impact dependent on what the technology reveals. Potential staffing implications for areas in which inefficiencies or opportunities to drive business value are uncovered |
|  |  |  | Representative Workflow Impact: All workflow implications depend on the results of analyses run within each system. Business intelligence tools can help leaders identify strategies to enhance clinical quality, improve productivity, or manage costs, often through process improvements or other changes to workflow | Representative Staffing Impact: Staffing implications also depend on the outcomes of institution-specific analyses |  |

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1) Scope and magnitude of impact refers to impact on end-users of technology, not IT department staff.

Source: HR Investment Center interviews and analysis.
Tool #8: Cheat Sheet for Assessing Staffing and Workflow Implications of Health Care Technologies (cont.)

<table>
<thead>
<tr>
<th>Technological Innovation</th>
<th>Technology Description</th>
<th>Common Vendors</th>
<th>Workflow Impact</th>
<th>Staffing Impact</th>
<th>Key Staffing Insights</th>
</tr>
</thead>
</table>
| Mobility & Collaborative Technologies | Technologies that support the use of mobile devices (e.g., smart phones and tablets) | Devices:  
• Apple  
• Motorola  
• Samsung  
Mobile Device Management:  
• MobileIron  
• Boxtone  
• Airwatch  
• Good  
• Symantec | Scope of Impact:  
Magnitude of Impact:  
Representative Workflow Impact:  
Allow health care workers to access information from anywhere, without requiring them to return to their desk or work stations | Minimal, if any  
May enable the elimination of some waste in workflow but not enough to impact staffing | Will enable the elimination of some waste in workflow but not enough to impact staffing |
| Security and Management Technologies | Software that verifies the identities of individuals, organizations, and systems to secure access to (and exchange of) information | • VeriSign  
• Microsoft/Caradigm  
• Verison  
• Kryptiq  
• Equifax  
• Anakam | Scope of Impact:  
Magnitude of Impact:  
Representative Workflow Impact:  
• Creates the need for sign-on to access EMR, portals, HIEs, financial information, etc.  
• Single sign-on and context aware technologies can make the process of accessing and documenting patient information faster and more efficient | Minimal, if any  
May enable the elimination of some waste in workflow but not enough to impact staffing |
**Tool #8: Cheat Sheet for Assessing Staffing and Workflow Implications of Health Care Technologies (cont.)**

<table>
<thead>
<tr>
<th>Technological Innovation</th>
<th>Technology Description</th>
<th>Common Vendors</th>
<th>Workflow Impact&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Staffing Impact&lt;sup&gt;1&lt;/sup&gt;</th>
<th>Key Staffing Insights&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
</table>
| **Business Processing Technologies** | Systems that optimize the effectiveness and efficiency of a business process (such as revenue cycle or medication orders) through automation | • Integration-brokers  
• ERP vendors  
• TIBCO  
• IBM  
• Pegasystems  
• EMR vendors (e.g., Meditech, Cerner, Epic, McKesson, etc.) | Scope of Impact: ☐ ☐ ☐ | Magnitude of Impact: ☐ | Moderate staffing impact due to automation of administrative functions and new need for skilled users |
|                                  |                                                                                        |                                                                                 | Representative Workflow Impact:  
• Creates efficiency for many clinical and administrative functions by organizing, coordinating, and automating tasks, and streamlining communication  
• Automation can help streamline medical orders and tests, reducing duplication  
• Important to note that in early implementation phases, it is possible to see “negative workflow effects,” or increases in the time it takes staff to complete tasks; steep learning curves are common when introducing new automated processes | Representative Staffing Impact:  
• Departments with volumes-based staff may require fewer FTEs if automation eliminates duplication, driving down volumes  
• Reductions in charting time could dramatically reduce need for clerks  
• Could eliminate roles associated with certain manual processes (e.g., transcriptionists)  
• Could increase staffing need for skilled users to customize and optimize functionality, and educate others on proper use |
### Tool #8: Cheat Sheet for Assessing Staffing and Workflow Implications of Health Care Technologies (cont.)

<table>
<thead>
<tr>
<th>Technological Innovation</th>
<th>Technology Description</th>
<th>Common Vendors</th>
<th>Workflow Impact</th>
<th>Staffing Impact</th>
<th>Key Staffing Insights</th>
</tr>
</thead>
</table>
| **Tele-presence and Remote Monitoring Technologies** | Systems and sensors that allow caregivers to:  
- Monitor patients' conditions or activities  
- Deliver appropriate, efficient, timely care, even over remote distances | **Systems:**  
- Intel/GE  
- Honeywell  
- HomMed  
- Bosch (home monitoring)  
- Philips-VISICU  
- Cerner  
- iMDSoft (eICU)  
**Sensors:**  
- WellAWARE  
- Philips  
- GE  
- Honeywell  
- Bosch  
- OmronHubs  
- Capultech  
- iSIRONA  
- eTransX  
- Cambridge Consultants | Scope of Impact:  
Magnitude of Impact: |  
Representative Workflow Impact:  
- Creates completely new workflow for select caregivers by enabling remote monitoring of patient care  
- New responsibilities generated for nursing, administrative and other telehealth staff include: coordinating between remote providers and sites, maintaining telehealth equipment and data, establishing and documenting proper telehealth policies and procedures, and overseeing telehealth personnel and programs | Will greatly impact staffing, but only for the relatively small percentage of staff delivering and maintaining telehealth programs | Staffing Impact:  
Magnitude of Impact: |  
Representative Staffing Impact:  
- Likely to generate need for a handful of new or additional staff able to absorb new responsibilities  
- Could reduce the need for home health caregivers to routinely drive long distances, which may contribute to small reductions in clinical staff size |  

1) Scope and magnitude of impact refers to impact on end-users of technology, not IT department staff.

Source: HR Investment Center interviews and analysis.
Tool #9: Discussion Guide for Identifying Staffing Needs to Accomplish Near-Term EMR Goals

Recommended User: HR executive.

Goal: Detailed analysis of EMR programs by care setting, including current stage of implementation, business intelligence goals, and new staff skills required to execute.

Recommended Interviewee: IT executive.

Recommended Preparation: None.

Additional Resources: (Optional) Bring a copy of the Notes Page at the end of this Discussion Guide to facilitate note-taking.

Estimated Time Required: Approximately 30 minutes.

Available Online: The discussion guide is presented below, with notes that will help you lead the conversation. To access an editable version of the guide, please visit our website at advisory.com/hric/workforceplanning.

Discussion Questions

Clarifying Current and Future EMR Capability

1. For each facility in our organization, what best describes its current stage of EMR adoption?

2. In which care settings and/or facilities do you plan to aggressively push our EMR capabilities?
   a. Where do you want each of those care settings to be three years from now?
   b. What is the gap-to-goal for these care settings and facilities?
   c. What is your timeline for each of these care settings and facilities?

Guidance for Leading the Discussion

This section helps you assess the current state of EMR rollout across the organization and uncover near-term plans for enhancing EMR capabilities.

The goal is to understand where each facility currently falls on the spectrum of EMR adoption. The name your IT executive uses to describe each stage is less important than understanding the current progress. Examples of what organizations look like at each stage are provided below:

- **Acquisition:** In the process of selecting a vendor and determining how the organization wants the EMR to be customized
- **Installation:** Installing the EMR and training staff for go-live
- **Utilization:** Working to integrate electronic documentation into caregivers’ daily workflow and establish infrastructure for the long-term use and maintenance of the system
- **Optimization:** Working to use EMR data to inform process improvement plans, promote evidence-based care, and advise our organization’s business intelligence strategies

Even if the organization is still in the early stages of EMR rollout, having this discussion with IT leaders will still yield useful information about near-term plans to enhance EMR capabilities and enable HR to proactively introduce staffing options to meet future needs.

Source: HR Investment Center interviews and analysis.
Tool #9: Discussion Guide for Identifying Staffing Needs to Accomplish Near-Term EMR Goals (cont.)

**Discussion Questions**

3. What is the current level of analysis we’re able to perform on data in our EMR? (Would you characterize it as primarily descriptive, prescriptive, or predictive?)
   a. How do you anticipate these capabilities will evolve?
   b. What is your predicted timeline?

4. In three to five years, what level of analysis would you like to be able to perform on the data in our EMR?

5. Are there certain care settings, facilities, departments, and units where running a certain type of analysis will be especially important?
   a. Which ones?
   b. What’s our timeline for achieving this?
   c. What are the greatest potential obstacles to achieving this?

**Guidance for Leading the Discussion**

The goal is to understand the current level of business intelligence within your EMR. The name your IT executive uses to characterize the BI capabilities is less important than understanding the actual capabilities. Examples of the varying levels of EMR analytics are provided below:

- **Descriptive**: Analyzing EMR data to determine what happened in the past
- **Predictive**: Analyzing EMR data to forecast what might happen in the future
- **Prescriptive**: Analyzing EMR data to prescribe what to do in the future

The answer to this question will affect staffing only if the answer is the lack (or inadequacy) of current human capital resources.

However, it is also helpful for HR to know if the organization is being held back by the technology itself, as it could prevent pressure by technology owners and users to bring on new staff to achieve something that is ultimately unachievable with the current platform.

This section helps you identify the types and number of staff you need to achieve the desired level of EMR capability. Questions 6 and 7 help you uncover the skills and types of roles that best suit various levels of EMR analytics.

**Determining Current and Future EMR Staffing Need**

6. What type of informatics staff do we currently have dedicated to EMR?
   a. How many?
   b. What are their primary responsibilities with respect to EMR?
   c. Were any of these informaticists brought on primarily for EMR installation?
      i. How many, and who, did you keep (or plan to keep) after installation?
      ii. What are (or will be) their primary responsibilities?

7. To achieve your desired level of EMR capability in the next three to five years, do you know the type of staff you will need?
   a. What key skills should they exhibit?
   b. Do these staff already exist within the organization?
   c. If not, when should we think about bringing in new types of staff?

Source: HR Investment Center interviews and analysis.
Tool #9: Discussion Guide for Identifying Staffing Needs to Accomplish Near-Term EMR Goals (cont.)

Discussion Questions

8. Are there any particular types of roles or professions you think would be particularly well suited to fill skill gaps?

9. How is your informatics staff organized? (e.g., by function or by clinical department)
   a. Who do these staff report to?
   b. Do you think this structure allows your informaticists to fulfill the role you’ve outlined for them in the organization’s EMR?
   c. If not, what isn’t working?
   d. If the department will be organized by clinical department: Will data analysis be tailored to specific clinical areas?
      i. If so, do you think it would be preferable for informaticists to have any specific clinical expertise or experience?

Guidance for Leading the Discussion

For organizations aspiring to descriptive analytics capabilities, librarians and catalogers often have the requisite data skills.

Those moving toward predictive analysis often look for researchers or actuaries.

Those moving to prescriptive analytics often look for logistics, industrial, and clinical engineers.

These questions are optional, but recommended. If pressed for time, skip them.

Once you know the type of IT staff needed, the next step is to organize IT staff to achieve EMR goals. These questions are designed to help operational leaders think through how best to structure informatics staff to advance organizational goals.

Source: HR Investment Center interviews and analysis.
**Tool #9: Discussion Guide for Identifying Staffing Needs to Accomplish Near-Term EMR Goals (cont.)**

**Notes Page (Optional)**

**Recommended User:** Executive-level HR leader.

**Recommended Use:** Use the table below to take notes for Questions 1-8.

<table>
<thead>
<tr>
<th>Care Setting/Facility</th>
<th>Stage of EMR Adoption (Question 1)</th>
<th>Business Intelligence Ambition (Question 2, 3, 4)</th>
<th>Departments/Units Most Impacted (Question 5)</th>
<th>Skills Desired/ Roles Needed (Questions 7, 8)</th>
</tr>
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</tbody>
</table>

Source: HR Investment Center interviews and analysis.
Tool #10: Discussion Guide for Identifying Staffing Needs to Accomplish Telehealth Goals

**Recommended User:** HR business partner, unless the interview subject is a clinical executive. If so, an HR executive should lead the discussion.

**Goal:** Detailed analysis of new roles and certifications required for telehealth programs, broken down by administrative, nursing, and clinical support staff.

**Recommended Interviewee:** If your organization has an established telehealth program or programs, speak with the executive or directors overseeing each program. If your organization does not have an established telehealth program, identify a clinical executive likely to lead this effort (most commonly the chief medical officer, chief nursing officer, or VP of ambulatory services).

**Recommended Preparation:** None.

**Additional Resources:** (Optional) Bring a copy of the notes page at the end of this discussion guide to facilitate note-taking.

**Estimated Time Required:** Approximately 1 hour per leader.

**Available Online:** The discussion guide is presented below, with notes that will help you lead the conversation. To access an editable version of the guide, please visit our website at advisory.com/hric/workforceplanning.

## Discussion Questions

### Clarifying Current and Future Telehealth Plans

1. Does our organization use any telehealth technology? If so, what kind?
   - a. Technology that stores and forwards data? For example, technology that lets us send x-rays to off-site radiologists electronically.
   - b. Live video consults?
   - c. Technology that allows us to monitor patients' vitals and symptoms remotely, while they are at home?

2. Does our organization currently have (or plan to develop) specific telehealth programs?
   - a. For which service lines or departments?
   - b. What types of telehealth programs do each of these service lines/departments offer (or plan to develop)?
   - c. What is the anticipated timeline for establishing these offerings?

3. Are decisions about telehealth programs made at the system level—or within each service line/department?

### Guidance for Leading the Discussion

- **This section helps you assess the current state of existing telehealth programs and future plans for telehealth. It also helps you identify the owners of telehealth programs across the organization.**

- **If your interviewee appears unsure of the organization’s current plans for telehealth or does not provide a clear and concrete response, you can use the bullets provided here to prompt him or her with an example of three common models of telehealth.**

- **If the telehealth decision-making process is largely centralized, and the leader with whom you are speaking oversees it, continue the current conversation.**

- **If it is primarily decentralized, and leaders other than the one with whom you are speaking individually oversee various telehealth offerings, collect the names of the relevant leaders. Follow up with the identified executives to learn more about their telehealth plans and staffing needs.**

Source: HR Investment Center interviews and analysis.
Tool #10: Discussion Guide for Identifying Staffing Needs to Accomplish Telehealth Goals (cont.)

Discussion Questions

a. If decision making and governance is decentralized, which leaders oversee each of the telehealth programs you mentioned earlier?

b. Do you see this changing at all in the near future?

Determining Telehealth Program Staffing Needs

For administrative staff:

4. For this telehealth model, what new administrative responsibilities will be created?

   a. Will our current administrative staff have the capacity to absorb these new responsibilities?

   b. If not, what type of staff member (either currently employed or new) would be best suited to take on each of these responsibilities?

   c. Do you expect that these new responsibilities will require a total FTE? Or part of an FTE?

5. For this telehealth model, will the administrative staff need any specific qualifications?

6. Will administrative staff be wholly dedicated to telehealth, or will they split their time between telehealth and other responsibilities?

7. Will they focus on a specific program, or will they assist with larger organizational telehealth efforts?

For nursing staff:

8. For this model, will any new nursing responsibilities be created? What do you expect they will be?

   a. Will existing nursing staff have the capacity to absorb these new responsibilities?

Guidance for Leading the Discussion

This section helps you identify the new responsibilities created by each telehealth model. It also helps you determine whether new roles will be needed to take on some of these responsibilities.

For each type of telehealth technology that your organization currently offers (or intends to offer in the near future), ask questions 4–15.

If your leader has trouble identifying concrete responsibilities, it may be useful to prompt him or her with some of the common administrative responsibilities below.

Live consults:
- Act as liaisons between hub and spoke hospitals
- Serve as primary contact for scheduling live consult sessions
- Manage administrative tasks (e.g., licensing, billing, etc.)

Remote monitoring:
- Organize patient records, maintain privacy and security of patient data collected from telehealth devices
- Schedule follow-up appointments with patient providers
- Manage administrative tasks (e.g., grants, etc.)

If your leader has trouble identifying concrete responsibilities, it may be useful to prompt him or her with some of the common nursing responsibilities below.

Live consults:
- Assist with intake and triage
- Introduce patient to technology and remote provider
- Provide training to staff at spoke sites

Remote monitoring:
- Conduct home visits, provide clinical interventions, and educate patients
- Monitor incoming patient data, alert physicians as necessary
- Check in with patients via phone

Source: HR Investment Center interviews and analysis.
Tool #10: Discussion Guide for Identifying Staffing Needs to Accomplish Telehealth Goals (cont.)

Discussion Questions

b. If not, are there any responsibilities that your nurses currently perform that they should delegate down?
   i. Which responsibilities should they delegate?
   ii. Who do you think they should delegate these responsibilities to?
   iii. Are there any responsibilities they should simply let go?
      1. What do you think prevents them from letting go of these responsibilities entirely? (Is something preventing you from telling them to let them go, or are they continuing to do it even after you’ve told them to stop?)

c. If they delegated down all of the responsibilities that we just discussed, would your nurses have the capacity to add these responsibilities to their workflow?

d. Do you think you’ll need new nursing staff to fulfill these new responsibilities?

9. Will nursing staff be wholly dedicated to telehealth, or will they split their time between telehealth and other responsibilities?

10. Will they focus on a specific program, or will they assist with larger organizational telehealth efforts?
   a. (For live consults), will nursing staff be needed at hub or spoke sites?

11. For this model, will nurses need any specific qualifications, education, credentials, or certifications?
   For clinical support staff:
   12. For this model, will any new responsibilities be created for clinical support staff? What do you expect they will be?
      a. Will our clinical support staff have the capacity to absorb these new responsibilities?
      b. If not, are there any responsibilities that your clinical support staff currently perform that they should delegate down?

Guidance for Leading the Discussion

Off-loading direct patient care responsibilities from nurses to support staff can be a sensitive topic. Nurses often want to continue performing direct patient care responsibilities, because of concerns about safety or to maintain their connection with patients. If nurse leaders are hesitant or uncomfortable discussing responsibilities to off-load, frame the questions in a way that conveys the need to protect RN time so they can productively perform work only an RN can do.

Live consults are often structured after a hub-and-spoke model:
- Hubs are often tertiary care centers or a system’s flagship hospital.
- Spokes (also known as satellites) are typically in rural or underserved areas, and are often community hospitals within a system.
Tool #10: Discussion Guide for Identifying Staffing Needs to Accomplish Telehealth Goals (cont.)

**Discussion Questions**

i. Which responsibilities should they delegate?

ii. Who do you think they should delegate these responsibilities to?

iii. Are there any responsibilities that they should simply let go?

1. What do you think prevents them from letting go of these responsibilities entirely? (Is something preventing you from telling them to let them go, or are they continuing to do it even after you’ve told them to stop?)

c. If they delegated down all of the responsibilities that we just discussed, would your clinical support staff have the capacity to add these responsibilities to their workflow?

d. Do you think you’ll need new nursing staff to fulfill these new responsibilities?

13. Will clinical support staff be wholly dedicated to telehealth, or will they split their time between telehealth and other responsibilities?

14. Will they focus on a specific program, or will they assist with larger organizational telehealth efforts?

a. (For live consults), will these staff be located at hub or spoke sites?

15. For this model, will support staff need any specific qualifications, education, credentials, or certifications?

**Guidance for Leading the Discussion**

Source: HR Investment Center interviews and analysis.
Tool #10: Discussion Guide for Identifying Staffing Needs to Accomplish Telehealth Goals (cont.)

### Discussion Questions

**Considerations for Nurse Practitioners and Physicians Working in Telehealth**

16. Will providers working in telehealth require any additional licensure or credentials?
   - a. Will providers be delivering services across state lines?
   - b. Does the organization have any credentialing rules beyond those required at the state level?

17. Will physicians and NPs involved in telehealth need to off-load other responsibilities to free up time to deliver telehealth?
   - a. Who will take on those responsibilities?
   - b. Will we need to add providers as we add this new service?

### Guidance for Leading the Discussion

Providers often need special credentials to offer telehealth services. This section prompts operational leaders to consider if their providers are currently prepared to offer telehealth services.

Source: HR Investment Center interviews and analysis.
Tool #10: Discussion Guide for Identifying Staffing Needs to Accomplish Telehealth Goals (cont.)

Notes Page (Optional)

**Recommended User:** HR business partner, unless the interview subject is an clinical executive. If so, an HR executive should lead the discussion.

**Recommended Use:** Use the table below to take notes for Questions 4-15.

<table>
<thead>
<tr>
<th>Staff Type</th>
<th>New Responsibilities</th>
<th>Responsibilities to Delegate Down</th>
<th>Responsibilities to Stop Doing</th>
<th>Capacity Concerns</th>
<th>New Roles Needed</th>
<th>Training/Certifications Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative</td>
<td>(Questions 4, 8b, 12b)</td>
<td>(N/A)</td>
<td>(N/A)</td>
<td>(Question 4a)</td>
<td>(Question 4b)</td>
<td>(Question 5)</td>
</tr>
<tr>
<td>Nursing</td>
<td>(Question 8)</td>
<td>(Question 8bi, 8bii)</td>
<td>(Question 8biii)</td>
<td>(Questions 8a, 8c)</td>
<td>(Question 8d)</td>
<td>(Question 11)</td>
</tr>
<tr>
<td>Clinical Support</td>
<td>(Question 12, 8b)</td>
<td>(Questions 12bi, 12bii)</td>
<td>(Question 12biii)</td>
<td>(Question 12c)</td>
<td>(Question 12d)</td>
<td>(Question 15)</td>
</tr>
</tbody>
</table>

Source: HR Investment Center interviews and analysis.
Section IV: Internal Executive Staffing Imperatives

Identify Organizational Plans for Two Most Common Staffing Initiatives

Rationale

In addition to key industry-wide changes affecting staffing, many organizations are pursuing internal initiatives that will also impact their future workforce. Examples include voluntarily adopting nurse-to-patient staffing ratios, seeking external award designation, or elevating education requirements for clinical staff. The motivation for these internal executive imperatives range dramatically, from market competition to avoiding union activity.

Regardless of motivation, two specific initiatives promise to have the most dramatic impact on future staffing need—increasing the percentage of BSN nurses and achieving patient-centered medical home (PCMH) designation. And both types of initiatives are increasingly common. For example, 23% of organizations now require all new nurse hires to achieve a BSN within the first five years of employment,1 and the number of NCQA-recognized medical homes quadrupled from 2009 to 2010.2

HR must be an active partner in planning both these initiatives. While, operational leaders will need to lead, HR should be involved in the early planning stages to proactively identify and address staffing implications. Otherwise, the risk is leaders may set a BSN percentage or medical home strategy without fully considering the requisite staffing implications.

Primary HR Objective

To account for the impact of internal executive imperatives on staffing need, HR must identify the organization’s exact goals for BSN requirements and PCMH achievement. More importantly, HR needs to help executive leaders understand the staffing trade-offs necessary to achieve those goals.

To do so, HR must first understand the organization’s desired BSN percentage and work with nursing leaders to agree on strategies and a timeline for achieving that goal. Second, HR leaders should identify executives’ short- and long-term plans for building PCMHs. Finally, HR must work with the operational leaders overseeing these new medical homes to determine if new staffing responsibilities are required and which staff should own them. The tools in this section will help HR leaders and business partners with each of these steps.

Tools Overview

<table>
<thead>
<tr>
<th>Tool</th>
<th>Intended Users</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool #11: Discussion Guide for Uncovering Organizational Strategy for Increasing BSN Percentage</td>
<td>HR executive</td>
<td>Inventory of strategies HR and nursing leaders will pursue to achieve desired BSN percentage goal</td>
</tr>
<tr>
<td>Tool #12: Discussion Guide for Identifying Executive Priorities for Patient-Centered Medical Home Transition</td>
<td>HR executive</td>
<td>List of primary care sites preparing to transition to PCMHs and assessment from clinical executive on whether current staff can meet new responsibilities</td>
</tr>
<tr>
<td>Tool #13: Discussion Guide for Efficiently Allocating Patient-Centered Medical Home Responsibilities Across the Care Team</td>
<td>HR executive or HR business partner</td>
<td>Detailed allocation of new PCMH responsibilities to current care team members</td>
</tr>
</tbody>
</table>

Section IV: Internal Executive Staffing Imperatives

Identify Organizational Plans for Two Most Common Staffing Initiatives

How to Use These Tools

**HR Executives:** Tool #11 helps HR executives identify plans to increase the percentage of nursing staff with BSNs. Tool #12 helps HR executives identify plans to transition primary care sites to patient-centered medical homes and learn clinical executives’ overarching preferences for PCMH care team structure and team member responsibilities.

**HR Business Partners:** Tool #13 helps business partners hold concrete conversations with clinical leaders about the ideal distribution of responsibilities within their PCMH care teams.
Tool #11: Discussion Guide for Uncovering Organizational Strategy for Increasing BSN Percentage

**Recommended User:** HR Executive.

**Goal:** Inventory of strategies HR and nursing leaders will pursue to achieve desired BSN percentage goal.

**Recommended Interviewee:** Chief Nursing Officer.

**Recommended Preparation:** Come to the interview with a thorough understanding of your local market’s BSN pipeline. In addition to the standard analyses, consider whether any local competitors are likely to increase their BSN recruitment efforts.

**Additional Resources:** None.

**Estimated Time Required:** Approximately 45 minutes to one hour.

**Abbreviated Guide:** If pressed for time, focus on questions in bold. This should require approximately 30 minutes.

**Available Online:** The discussion guide is presented below, with notes that will help you lead the conversation. To access an editable version of the guide, please visit our website at advisory.com/hric/workforceplanning.

### Discussion Questions

**Clarifying the BSN Goal**

1. What is your target percentage of BSNs?
2. When do you hope to reach this target?
3. What is the current percentage of BSNs among our nursing staff?

**Exploring Potential Strategies for Achieving the BSN Goal**

4. Do you have any strategies in mind for increasing the percentage of BSNs?
   a. If so, what are they?
   b. How did you decide upon these particular strategies?
5. I know that some organizations pursuing BSN goals have restricted hiring to BSNs only. Do you think we should consider a similar hiring restriction?
   a. If not, do you think that we should give BSNs hiring priority over ADNs?
6. If we do continue to hire ADNs, should we hire them only with the understanding that they will enroll in a program to earn a BSN?
   a. How much time should we give them to earn a BSN?
   b. Should we offer tuition reimbursement?

**Guidance for Leading the Discussion**

- This section will open the conversation with a mutual understanding of the overall magnitude of the initiative.

- The goal of this section is to identify the proper strategy for your organization, so it is important to put all potential options on the table.

- Of course, your understanding of your historical recruiting patterns and openings will help inform the conversation (and the viability a BSN-only hiring policy).

Source: HR Investment Center interviews and analysis.
Tool #11: Discussion Guide for Uncovering Organizational Strategy for Increasing BSN Percentage (cont.)

**Discussion Questions**

7. Should we require currently employed ADNs to pursue a BSN?
   a. If we do want to require current staff to pursue BSNs, should we make exceptions for any current ADNs? For example, maybe nurses who are over a certain age or who have been with the organization for a certain number of years?

8. Should we incentivize currently employed ADNs to pursue BSNs?
   a. If we do want to offer incentives, what should they be?
      i. Examples that I have heard in the past include tuition reimbursement and a pay differential for BSNs. Should we use either of these incentives? Both?
      ii. If we want to offer a pay differential for BSNs, how much more should we pay them than ADNs?
      iii. Should we alter the way that we divide work and responsibilities between ADNs and BSNs?
      iv. If we want to offer tuition reimbursement, should we require that anyone receiving the incentive commit to remaining at the organization for a certain number of years after earning a BSN?
      v. Aside from tuition reimbursement, how can we make it as easy as possible for our employed ADNs to earn BSNs?
         1. For example, could we offer them more flexible scheduling?

**Guidance for Leading the Discussion**

Decisions regarding pay and work differentials must be heavily informed by the understanding that while it can be problematic to pay nurses different amounts for the same work, differentiating BSN and ADN work can be politically and operationally difficult.

**Determining Timeline for Implementation**

9. What timeline do you envision for rolling out each of these policies?

10. Are there any departments in which you think it is particularly important to increase the percentage of BSNs right away—that you would prioritize over other departments?

Source: HR Investment Center interviews and analysis.
## Tool #11: Discussion Guide for Uncovering Organizational Strategy for Increasing BSN Percentage (cont.)

### Discussion Questions

#### Isolating Strategies for BSN Recruitment

11. Are there specific institutions that you prefer we recruit from?

12. Are there sources of BSNs we aren’t currently recruiting from that you would like me to reach out to?
   - a. Should we strengthen our ties with any local schools?
   - b. What additional strategies have you considered?
   - c. What are the big barriers that you face?
   - d. How can I help?

#### Closing Thought: Considering Impacts on Other Goals

13. Are you considering any other workforce initiatives on a similar timeline?
   - a. What are the goals of the initiatives?
   - b. If these initiatives begin to conflict, which one would you like to prioritize?
     - i. Do you consider any more important than the BSN initiative?
     - ii. Do you think that any of them are more time-sensitive than the BSN initiative?

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Changing the percentage of BSNs will inherently inflect other workforce demographics. **The goal of this section is to identify whether BSN initiatives may conflict with any other initiatives—and if so, which one has priority.**
Tool #12: Discussion Guide for Identifying Executive Priorities for PCMH Transition

Revised User: HR executive.

Goal: List of primary care sites preparing to transition to PCMHs and assessment from clinical executive on whether current staff can meet new responsibilities.

Recommended Interviewee: Executive overseeing the system’s patient-centered medical home efforts. Likely owners include the VP of ambulatory services, chief medical officer, or chief integration officer.

Recommended Preparation: None.

Additional Resources: None.

Estimated Time Required: Approximately 20 minutes.

Abbreviated Guide: If pressed for time, focus on questions in bold. This should require approximately 10 minutes.

Available Online: The discussion guide is presented below, with notes that will help you lead the conversation. To access an editable version of the guide, please visit our website at advisory.com/hric/workforceplanning.

Discussion Questions

Clarifying Plans for PCMH Transition

1. Do we plan for any of our primary care centers to transition to become PCMHs?
   a. If so, which sites?
   b. What is the timeline for each transition?
   c. Should any of these sites be prioritized over others, in terms of staffing for the transition?

2. Do you plan on overseeing the staffing of our PCMH sites?
   a. If so, will all PCMH sites be staffed identically?
   b. If not, will PCMH staffing decisions be made at the system level or at each care site?
      i. Who will be overseeing these decisions?

Guidance for Leading the Discussion

This section will open the conversation with a shared understanding of the magnitude of the transition to PCMHs.

Of equal importance, it will allow you to identify which operational leaders your business partners should follow up with to learn about their desired PCMH care team structure.

If an executive will oversee PCMH care team staffing, an HR executive (rather than an HR business partner) should continue the conversation using Tool #13, “Efficiently Allocating PCMH Responsibilities Across the Care Team.”

Keep in mind, Tool #13 is intended for managers and questions may need to be modified for an executive audience.

Source: HR Investment Center interviews and analysis.
Tool #12: Discussion Guide for Identifying Executive Priorities for PCMH Transition (cont.)

Discussion Questions

Assigning New PCMH Responsibilities

3. What are the current roles included in your primary care teams?

4. Please review the list of responsibilities below. Do you think this list covers all of the relevant responsibilities that we will have to take on in the transition to a PCMH?
   a. Is there anything missing from the list?
   b. Are there any responsibilities on the list that are not relevant to us?
      i. Pre-visit planning
      ii. Patient self-management support
      iii. Group visit facilitation
      iv. Coordinating inpatient stays and discharges with acute care facilities
      v. Coordinating referrals to specialists
      vi. Population management data entry
      vii. Population management data analysis
      viii. Well-patient check-ups
      ix. Non-emergent acute visits (e.g., for a sore throat)
      x. After-hours and weekend visits
      xi. Triaging patient questions and requests

5. Are current care team members equipped to take on these new responsibilities?
   a. Do you think that any new roles should be added to the care team to take on particular responsibilities?
      i. What should this role be?
      ii. Which responsibilities would this person take on?
      iii. What type of caregiver or support staff should fill it?

Guidance for Leading the Discussion

It is important to understand the executive perspective on how PCMH responsibilities should be distributed among care team members.

However, business partners will be able to gain much more specific information when they speak with the leaders directly overseeing PCMH care team staffing. Both perspectives are important when crafting a staffing blueprint for PCMHs.

The goal is to gain context for the rest of the conversation. If the answer is overly vague or lofty, move on the next question.

An executive will be uniquely positioned to articulate the organization’s expectations for their PCMH care teams.

The HR executive should share the executive’s perspective with business partners before they follow up with operational leaders. It will be essential that business partners have a clear and accurate understanding of the new responsibilities a PCMH care team will need to assume. If not, they won’t be able to accurately identify the most efficient allocation of those responsibilities across the care team.

Source: HR Investment Center interviews and analysis.
Tool #13: Discussion Guide for Efficiently Allocating PCMH Responsibilities Across the Care Team

**Recommended User:** HR business partner, unless the interview subject is a clinical executive. If so, an HR executive should lead the discussion.

**Goal:** Detailed allocation of new PCMH responsibilities to current care team members.

**Recommended Interviewee:** Manager- or director-level operational leaders with oversight of care transitions or care transitions initiatives. A prior interview with executive-level leaders will help you identify who to speak with. If following up with multiple operational leaders, speak with each leader individually.

**Recommended Preparation:** None.

**Additional Resources:** (Optional) Bring copies of the notes page at the end of this discussion guide to facilitate note taking.

**Estimated Time Required:** Approximately one hour per leader.

### Discussion Questions

**Understanding the Current Primary Care Team Structure**

1. What types of caregivers work in your unit/care area?
2. How many of each?

**Assigning New PCMH Responsibilities**

3. Please review the list of responsibilities below. Do you think this list covers all of the relevant responsibilities that your care team will have to take on in the transition to a PCMH?
   a. Is there anything missing from the list?
   b. Are there any responsibilities on the list that are not relevant to us?
      i. Pre-visit planning
      ii. Patient self-management support
      iii. Group visit facilitation
      iv. Coordinating inpatient stays and discharges with acute care facilities
      v. Coordinating referrals to specialists
      vi. Population management data entry
      vii. Population management data analysis
      viii. Well-patient check-ups
      ix. Non-emergent acute visits (e.g., for a sore throat)
      x. After-hours and weekend visits
      xi. Triaging patient questions and requests

### Guidance for Leading the Discussion

The goal of this section is to obtain concrete information about the number and type of staff on the care team. This will provide needed context for conversations about how PCMH responsibilities can be best allocated across the team.

During the transition to become a PCMH, it is likely that new responsibilities will be added.

This section aims to determine:
- If the current care team can assume these responsibilities
- If so, who on the team
- And if not, which new roles may need to be added

Your HR executive will probably have run this list by an executive leader with PCMH oversight. If they have, discuss the results of that conversation in tandem with the list presented here.

**It is still essential that you ask these questions during this conversation.** Responsibilities may be unequally distributed across PCMH sites, and the leader with whom you are speaking is more likely to have an on-the-ground perspective of the discreet responsibilities that must be accounted for in the transition to a PCMH.
Tool #13: Discussion Guide for Efficiently Allocating PCMH Responsibilities Across the Care Team (cont.)

**Discussion Questions**

*For each of the above responsibilities (and any others added in the conversation) ask the following questions:*

4. Setting aside current workload for the moment, do any current care team members have the necessary skills and qualifications to take on this new responsibility?
   a. If so, who?
   b. If not, should a role be added to the care team to ensure adequate coverage of this responsibility?
      i. What should this role be?
      ii. What type of caregiver or support staff should fill it?

**Assessing Care Team Members’ Capacity for Added Responsibilities**

*Ask the following questions for each member of the care team who may be taking on new responsibilities. Start with the highest-level provider (e.g., physician or advanced practitioner):*

5. Do you think the staff members in this role have the capacity to add these new responsibilities to their current workload?

6. If not, are there responsibilities they currently perform that they should delegate down?
   a. Which responsibilities should they delegate?
   b. Who do you think they should delegate these responsibilities to?
   c. Why don’t staff delegate these responsibilities down?
      i. Are they uncomfortable working at the top of their license—perhaps due to technical challenges—or with others doing so?
      ii. Or do they find that there is no one qualified available to delegate work to?

**Guidance for Leading the Discussion**

This section aims to identify the ideal distribution of PCMH responsibilities within a PCMH care team. It will also identify if any new members need to be added to the care team.

These questions should push operational leaders to think about the work on their unit that needs to get done—as opposed to the number of FTEs. It is important to guide the conversation to specific responsibilities.

You will want to prompt operational leaders to speak about caregiver responsibilities at the same level of detail as the responsibilities listed under question 3.

It is possible the care team members identified as ideal owners of new PCMH responsibilities do not currently have capacity to add responsibilities to their workload.

However, it is worth exploring to see if these caregivers could free up capacity for new PCMH tasks by working at top-of-license and delegating more tasks to other caregivers.

Tasks that may be able to be off-loaded to support staff include:
- Rooming patients
- Taking blood pressure

*Source: HR Investment Center interviews and analysis.*
Tool #13: Discussion Guide for Efficiently Allocating PCMH Responsibilities Across the Care Team (cont.)

**Discussion Questions**

d. Are there any responsibilities that they should simply let go?
   
i. What do you think prevents them from letting go of these responsibilities entirely? (Is something preventing you from telling them to let them go, or are they continuing to do it even after you’ve told them to stop?)

7. If they delegated down all of the responsibilities that we just discussed, would they have the capacity to add these new responsibilities to their workflow?
   
a. If not, is it the right answer to add more FTEs in this role?
   
b. Should a new role be introduced instead?
## Tool #13: Discussion Guide for Efficiently Allocating PCMH Responsibilities Across the Care Team (cont.)

### Notes Page (Optional)

**Recommended User:** HR business partner, unless the interview subject is a clinical executive. If so, an HR executive should lead the discussion.

**Recommended Use:** Use the table below to take notes for Questions 3-7.

<table>
<thead>
<tr>
<th>Care Team Member</th>
<th>New Responsibilities (Questions 4, 6)</th>
<th>Responsibilities to Delegate Down (Question 6a)</th>
<th>Responsibilities to Stop Doing (Question 6d)</th>
<th>Capacity Concerns (Question 7)</th>
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Source: HR Investment Center interviews and analysis.
## Tool #13: Discussion Guide for Efficiently Allocating PCMH Responsibilities Across the Care Team (cont.)

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