The Business Impact of Learning: A Healthcare Case Study

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Using an embedded, single-case study, this paper explores learning opportunities in a worksite healthcare services firm and how the business impact of employee learning is measured. We applied grounded theory analytical procedures, with an eye to developing a theoretical model of the impact measurement process. The resulting model illustrates how practical issues created a fixed focus on clinical and regulatory requirements, inhibiting consensus about what constitutes learning impact measurement and the extent to which non-technical learning is valued in identifying employees for development and advancement. Lastly, we discuss implications for decision-makers in similar organizations.

INTRODUCTION

Workplace learning, the acquisition of knowledge or skills by formal or informal means that occurs in the workplace (Cacciattolo, 2015), has been studied fairly extensively. When viewed through the lens of organizational decision-makers at the operational and senior leadership levels, workplace learning tends to be viewed in terms of (a) its alignment with organizational goals, (b) its business impact, and (c) how that impact is measured and what metrics should be used (Davenport and Harris, 2007). Gaining insights into the relationship between workplace learning and business impact can be well served by what Manuti et al. (2015) called workplace learning research *in practice*, and one field that offers ample examples of *in practice* studies is healthcare.

The scope of research in healthcare work settings ranges from studies focusing on mandatory continuing medical education for specific occupations, specializations, and curricular interventions, to the design of technologies to support informal learning activities (see, for example, Hobgood et al., 2015; Sheng et al. 2013; van de Wiel et al, 2011; Willig et al., 2015). Although the goal of these studies has been to examine the impact of various types of learning on daily practice, the vast majority of workplace learning studies in healthcare are situated in traditional healthcare delivery settings such as hospitals and community-based clinics. Less attention has been paid to measuring the impact of learning in non-traditional settings such as worksite healthcare services firms.

Worksite healthcare services firms cross multiple functional domains within the healthcare sector and provide a variety of health services, ranging from walk-in treatment for work-related injuries, drug and alcohol screenings, to nutritional coaching and health risk assessments. Worksite healthcare services firms must acquire, serve, and retain clients, and have revenue models that are often based on fixed-rate, long-

term contracts to provide the services of practitioner and technical occupations in fluid locations as needed by the client. Worksite healthcare services firms can be found in countries with a variety of healthcare systems, such as South Africa (Occupational Care South Africa, n.d.), Canada (Medisys, n.d.), and Australia (Medical Services Australia, n.d.), although the breadth and depth of services varies from country to country. However, there are no well-established theories or models explaining how worksite healthcare services firms determine the business impact of learning.

This paper reports the results of an exploratory study of business impact measurement efforts at a U.S.-based worksite healthcare services firm, with an eye to constructing a theoretical model that will offer insights into the factors influencing the impact measurement process. The next section of this paper presents the theoretical context surrounding business impact measurement, including the research questions emerging from that context. Subsequent sections present the rationale for the methodological approach selected to address the research questions, and the resulting theoretical model. The paper concludes with a discussion of model implications, study limitations, and opportunities for further research.

THEORETICAL CONTEXT AND RESEARCH QUESTIONS

There have been several finance-based approaches to measuring the business impact of learning. For example, the Phillips approach defines business impact in terms of an organization's economic profitability and requires organizations to assign a monetary value to the outcomes of training events (Phillips, 1997a, 1997b). Other finance-based approaches include Robinson and Robinson's (1989) training cost-benefit model, Kaufman and Watkins (1996) Organizational Elements Model (OEM) training cost-consequences analysis, and Wang, Dou, and Li's (2002) systems approach to measuring the monetary and non-monetary return on investment (ROI) of learning and development investments. Efforts to apply finance-based indicators to the business performance of worksite healthcare services firms are just getting underway, although studies to date focus more on service usage than on the contribution of learning to the business (Sherman & Fabius, 2012; Tao et al., 2009).

However, the finance-based measurement approaches have been challenged for a variety of reasons, including the omission of indicators that do not lend themselves to monetization (e.g., customer satisfaction, employee satisfaction), being backward-looking and thus, unhelpful for forecasting purposes, and for an almost exclusive focus on training (Russ-Eft & Preskill, 2005; Wang, Dou, & Li, 2002; Wang & Wang, 2005). Moreover, application of these models to the healthcare sector has not included non-traditional delivery settings.

There is some evidence to suggest that business impact measurement is organization- and industry sector- dependent. For example, a study conducted among large ($\geq$ 5,000 employees) professional services firms (PSFs) – classical PSFs such as law and accounting firms; professional campuses such as hospitals; new-PSFs such as management consulting firms; and technology developers such as R&D firms (Von Nordenflycht, 2010) - drew on the analytical techniques from grounded theory to explore how 15 decision-makers who are responsible for their firm's learning and development strategy measure the business impact of learning (van Rooij & Merkebu, 2015). The resulting theoretical model identified Win Rate (new business, contract extensions/renewals) as the core measure of business impact. However, none of the participants were using a formula/algorithm to assess the relative contribution of either the components of Win Rate or any other factors that contributed to the firm's wins. Moreover, the study's theoretical model could not fully explain (a) potential differences in measurement between regulated industry sectors such as healthcare versus sectors with fewer regulatory constraints, (b) potential differences in measurement among firms of various sizes, and (c) the perspectives of occupational functions other than Learning and Development professionals.

The lack of consensus about how to measure the business impact of learning suggests that worksite healthcare services firms might have their own definitions and approaches. Moreover, the growing popularity of worksite healthcare services firms among large employers (Lee et al., 2015; Umland, 2015) and the relatively high level of employer satisfaction with these firms, supports the notion that the

worksite healthcare services firm is a workplace context worthy of further study. Therefore, the present study explored the following research questions:

RQ 1: How does a worksite healthcare services firm define learning and thus, opportunities for learning?

RQ 2: What is the process used to develop and reach consensus about the definition of, and metrics/measures for business impact?

RQ 3: To what extent does the state of the business impact measurement process influence employee perceptions of a firm's commitment to learning?

METHOD

Study Design

The study consists of an embedded, single-case study in which the main unit of analysis is a firm that provides worksite clinics and associated ambulatory healthcare services. The firm's business units and occupational ranks were the embedded units of analysis. The rationale for selecting a single-case design was grounded in the nature of the research questions and the desire to build theory through particularization (Stake, 1995) rather than generalization to an entire industry. The selected firm was also in the process of developing processes, metrics and methods for assessing the contribution of learning to business performance. Thus, the case study was worth conducting because the descriptive nature alone would be revelatory (Yin, 2012). Lastly, the selected firm's organizational structure contains discrete business units that lend themselves to discrete analysis for comparative purposes, supporting the decision to employ an embedded design.

Organizational Setting

ABC Health Services (an alias to protect firm anonymity) offers telephone triage, on-site clinics, and mobile clinics to employers seeking to manage costs associated with worker health and workplace injuries. Headquartered in the U.S., ABC's corporate office centralizes core organizational functions such as sales, marketing, human resources, and medical compliance. However, the majority of the firm's employees are distributed nationwide. Since its founding in the early 1980s, the firm has grown to nearly 1,000 employees, the majority of whom are licensed or certified healthcare professionals (e.g., physicians, physician assistants, nurses, emergency medical technicians). The remaining employees possess diverse professional backgrounds, including business management, software development, information technology, and safety consultants, among others. At the time of the present study, 14 of the Fortune 100 companies were among ABC's clients.

Data Sources

Interviews

With the assistance of a firm liaison assigned to the researchers, participants were recruited via email describing the study. Thirty-four participants, 15 of whom were managers and 19 non-managers, were drawn from the three business units deemed most critical to the firm's mission, accounting for 83% of the firm's total revenue: Occupational Health, Advanced Practice, and Injury Triage. Two executives responsible for creating the firm's vision and strategy also agreed to participate. As shown in Figure 1, there are some differences in employee demographics among the three business units. For example, participants in Occupational Health tended to have the longest average tenure with the firm (16.3 years for managers and 5.5 years for non-managers) while Advanced Practice had the shortest 4.8 years and 3.5 years for managers and non-managers respectively). Managers with the greatest number of direct reports (57) were in Injury Triage, where many of the employees work the telephones from home. Nearly all participants tended to have some clinical background but only non-managers were practicing in their respective professional fields on a daily basis.

One-on-one telephone interviews were conducted over a six-month period. Interview questions were open-ended and focused on learning opportunities offered to employees; metrics and measures for determining the impact of learning at the individual, business unit, and organizational levels, and; perceptions of the firm's commitment to learning. Interviews were audio-recorded, averaged 32 minutes in length, and yielded 516 transcription pages. Each interviewee received a copy of his/her transcript to confirm accuracy of the content and to provide additional thoughts if desired. Participants were assured of anonymity through the use of aliases in lieu of names, with written confirmation that participation was voluntary and that they could withdraw at any time during the interview. The university Institutional Review Board approved the study (IRBNet ID 578335-1).

FIGURE 1
STUDY DESIGN
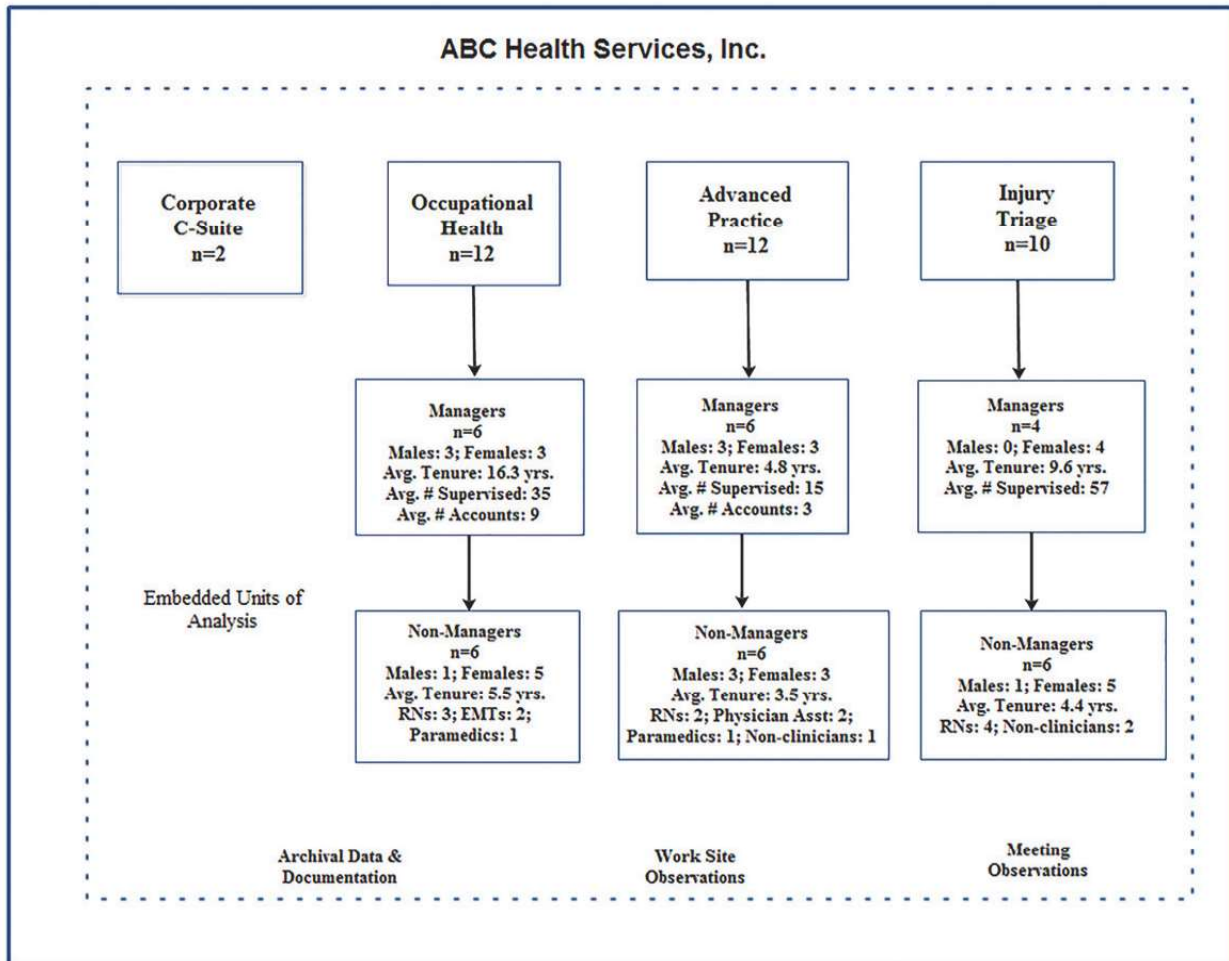
Archival and Publicly-Available Documentation
To gain familiarity with the firm and its business units and obtain a triangulating source of data, historical documents were requested and included annual reports distributed to employees and key stakeholders, as well as financial data for the past five years.

Worksite Observation
To gain a better understanding of day-to-day operations at a worksite clinic, the researchers visited a construction site in the mid-Atlantic region of the U.S. where the firm provides health screening services,

including drug and alcohol testing. The visit included conversations with the site leader, a walk-through of the site, and note-taking about processes and procedures.

Meeting Observation

The researchers attended (but did not actively participate in) a web-based business meeting of operations managers to gain insights into the types of learning-related topics discussed at such meetings. The meeting was audio-recorded to complement research notes.

Data Treatment

The present study employed grounded theory, a systematic methodology used to develop an explanatory theory of basic social processes, studied in the environments in which they take place, by examining contexts, contingencies, consequences, co-variances, and conditions, to understand the patterns and relationships among these elements (Glaser & Strauss, 1967; Strauss & Corbin, 1998). The researchers used the process of constant comparison, comparing source-to-source and identifying themes or patterns in the data that might help the researchers go beyond description to explanations of the relationships within the data, through three cycles of coding (open, axial, selective). The open coding cycle involved grouping statements into broad areas or codes, then grouping the open codes by categorizing them based on relationships and patterns within and among the categories identified in the data (axial coding). The process concluded when theoretical saturation (Bowen, 2008) was reached, no new concepts were emerging from the data and thus, no additional data needed to be collected.

FINDINGS

Learning Opportunities

The first theme emerging from the research concerned participant definitions of learning and learning opportunities (RQ 1). ABC Health Services executive participants articulated a clear, competency-based vision of the role of learning in achieving the firm's mission and goals, a vision that is consistent with the firm's public messages. Specifically, they deemed learning to be foundational, part of an iterative process in which each job has a set of performance-based competencies, a set of metrics and measures for these competencies, followed by an employee development plan to fill competency gaps. As one executive stated, "It's kind of like building a house, so foundationally, (a) what are the competencies, (b) find a way to measure them, and (c) build development plans that are succinct, that are competency-based in order to make that happen." Importantly, executives viewed learning as an enabler of future growth for the firm and as a way to maintain a competitive position in the market.

In contrast with the executives' competency-based view, employee participants (managers and non-managers) across all business units deemed learning to be much broader in scope, encompassing *any* information that supports performance to sustain the business. Learning opportunities mentioned most often included continuing medical education (CME) for clinical staff, HR-related training requirements as part of the onboarding process for new employees, annual corporate training requirements (e.g., sexual harassment, proprietary company software training), skill gaps or post-contract requests obtained from clients, and instances of training required by federal or state law (e.g., blood-borne pathogens, HIPAA). For example, one manager said:

> "My direct reports are all usually some type of licensed person, whether that is a medic, like a paramedic, an EMT and nurses in some fashion or a medical administrator or a medical assistant. So they all hold some titled license that they to go to school and then take some kind of formal test, like with the Nursing Board, to get the license, so they're required to keep up with continuing education. So, that is something that they have to do to maintain those licensures and so our department or our company offers a money value of $750.00 annually to that, that they can go out and seek other courses that they need to keep those CMEs so that they can renew their license."

> (Dorothy, Occupational Health, Manager)

Similarly, a non-manager in the Advanced Practice business unit said, "Well, you know, I feel committed, for keeping my job, I do all the mandatory things."

Other opportunities mentioned frequently were (a) work-related conversations, such as meetings and discussions with colleagues, with or without managers present; (b) the ABC corporate intranet with recorded webinars, presentations and other instructional materials; (c) professional conferences, and (d) the firm's tuition reimbursement process. Personal interest in a particular topic/field, self-motivation to learn new things, the desire to complete an undergraduate degree, and a search for anything that would support career advancement were the main drivers for taking advantage of available learning opportunities. One non-manager in the Advanced Practice business unit stated, "I try to find a course that maybe can cover some of the things where things are changing, or where I have weaknesses that I want to work on."

Non-managers mentioned that their managers encouraged some learning opportunities over others, with several mentioning the lack of learning opportunities for career advancement. One non-manager in Occupational Health stated, "As far as like leadership or learning opportunities to propel myself to a higher role, no." This was confirmed by a manager in Occupational Health who stated, "We have no career planning; we really haven't gotten there yet as an organization."

There was some variation in awareness of available learning opportunities. Non-managers from the Injury Triage business unit appeared to be less attuned to available learning opportunities than either Advanced Practice or Occupational Health, relying almost exclusively on supervisor support, the firm's intranet and email newsletters, due to heavy workloads from high call volume and thus, a lack of time to explore learning opportunities. For example, one non-manager from Injury Triage said:

> "Most of what we learn is through in-house teaching, webinars, through newsletters, our educational website within our intranet, and through information that we read over in our own intranet, and testing. We do have a test on the material and there is a follow-up by the Charge Nurses who audit our calls and assist us in correcting our errors and guiding us into a better way to handle the situation or to document or to focus our thoughts."
>
> (Jeanette, Injury Triage, Non-manager)

Further, non-managers across all business units felt that ABCs reliance on email to communicate non-mandatory opportunities was not particularly effective, nor was the content of the emails informative in terms of how a particular opportunity would advance knowledge or skills. For example, one non-manager stated:

> "Like I said, as far as those bi-weekly or monthly webinars they throw out, it's just an email saying, here's the topic of discussion, click this link to enroll yourself and that's just kind of it."
>
> (Don, Occupational Health, Non-Manager)

A manager in the same business unit agreed, stating "I don't know that these opportunities are necessarily advertised as well as they could be, but they're there." There was also some mention of the opportunities being redundant and not particularly relevant to specific worksite contexts.

Impact Measurement Process

In terms of business impact measures and processes (RQ 2), ABC executives sought to develop a consistent, systematic approach to business impact measurement that would support the firm's mission and goals. They expressed the desire to go beyond simply tracking licensure and certificate renewals and CME attendance, towards the ability to collect and analyze evidence that learning is being applied on the job at the individual, departmental, and organizational level. Some of the desired success measures included client retention, client base expansion, client satisfaction, revenue, as well as objective assessments of specific skills and competencies. There was also the recognition that an investment in people skilled in analytics is required to establish a process for transforming data into actionable business intelligence.

> "I would like to see that our employees are actually grasping that and actually finding a way to measure, whether that be through testing or whether that be through one-on-ones; that we start identifying the exact areas that we have to move forward. I think we have a good way to

benchmark people medically, the tools to benchmark, and the data to do that medically. What we don't have…and what I'm…increasingly finding out…and this is both from my operational managers, and from new people that are coming up, what we lack is the analytics, or the people that have the analytics, or understand how to look at this data, and to be able to come up with both observations of how they can move our business and the clients' business forward – move the needle so to say, and to be able to present that in a very succinct way."

(Allen, Executive Team)

However, learning impact measurement is fragmented, depending upon the business unit and on the degree to which individual field managers are proactive in the learning and development of their direct reports. Common to all three business units was the reliance on anecdotal evidence, such as verbal feedback from supervisors, or employees sharing the results of their learning activities with managers and colleagues, or compliments from clients. The second most common source of evidence was an employee's successful completion of required compliance training. Unique to Occupational Health, however, was the focus on value-added activities offered to clients, such as conducting meetings on behalf of a client, safety initiatives or partnering with a client to set up a health fair. For Injury Triage, call audits were the only formal mechanism for measuring the extent to which employees are applying their learning, while Advanced Practice tracked clinic patient volume, unit revenue, individual performance goals, and testing of specific skill sets.

There were also differences between what managers stated are the mechanisms for measuring impact and what non-managers believed were the measurement mechanisms. Specifically, managers were more likely than non-managers to mention their own follow-up with their direct reports, feedback to corporate headquarters, testing, and revenue as business impact measures. Where managers and non-managers agreed was on completion of mandatory compliance training as a measure of learning impact.

Much of the challenge to systematic measurement of learning concerned a lack of awareness of *what* to measure as well as how to measure it:

"But, for example, in customer service, you know. You can use some form of statistics. Will I get less complaints or more complaints? But really something like that you know. We're going to have to look over a period of time. Maybe use a patient satisfaction survey, to get a measurement. Or you know, a site visit if I need to go out and see how the person is in front of the patient. That is a little more difficult to measure, especially remotely. I don't get to see this person every day. So, I'm not sure – when I'm there are they on their best behavior? Probably. So that…that might take a little bit more time and getting more feedback from other employees. From patient's themselves."

(Will, Advanced Practice, Manager)

Commitment to Learning

To flesh out perceptions of ABCs commitment to learning (RQ 3), all interview participants were asked to imagine a 10-point continuum, with firms who believe that employees are responsible for their own learning at the lower end and firms who walk employees through their entire career on the upper end. Participants were then asked to place ABC along that continuum. Participants across all business units had varying views of where ABC lies on the continuum, with no differences between managers and non-managers or between those with longer tenure versus those with shorter tenure. When asked to give the reasons behind the ratings, common themes included an appreciation for the rigorous training during the onboarding process, for the organization's encouragement to learn, tempered against a lack of a rigorous, systematic plan to support learning beyond clinical and policy requirements.

Both managers and non-managers were very clear about what it would take to move ABC to a "10", mentioning most often improvements to the quality and relevance of learning opportunities to conditions at individual worksites. In addition, managers mentioned the need for ABC to do a better job of promoting and encouraging learning so that employees see the benefits of learning to ABC's clients, to themselves and to the organization as a whole, a comment echoed by the site manager during the researchers' worksite visit. In a similar vein, some managers mentioned that promoting learning also

promotes the ABC brand among employees. Another action mentioned that was needed to get ABC to a "10" was the creation of a centralized approach to documentation in order to track both mandatory and non-mandatory learning opportunities. Managers also noted the different learning needs of ABC's multigenerational workforce, and thus, the need to think more frequently about size, scope, frequency, and delivery format of learning opportunities. Non-managers, conversely, were singularly focused on the tuition reimbursement and the need to improve both the amount of the reimbursement and the process of applying for and redeeming reimbursement funds.

DISCUSSION AND IMPLICATIONS

The purpose of this research was to construct a theoretical model (shown in Figure 2) of how worksite healthcare services firms determine the business impact of learning through a grounded theory case study of one such firm. Moving from left to right through the model shows that manager and non-manager perceptions of learning impact measurement were characterized by (a) a fixed focus on learning for sustainability to the detriment of learning for advancement; (b) inconsistent measures across business units and; (c) a dependence on observation, anecdotal evidence, compliance training completion, client feedback, and employees sharing learning experiences. These factors appeared to "temper" their perceptions of ABC's commitment to learning, highlighting the gap between the current state of business impact measurement and the desired stated as envisioned by the firm's executives.

FIGURE 2
LEARNING IMPACT MEASUREMENT MODEL
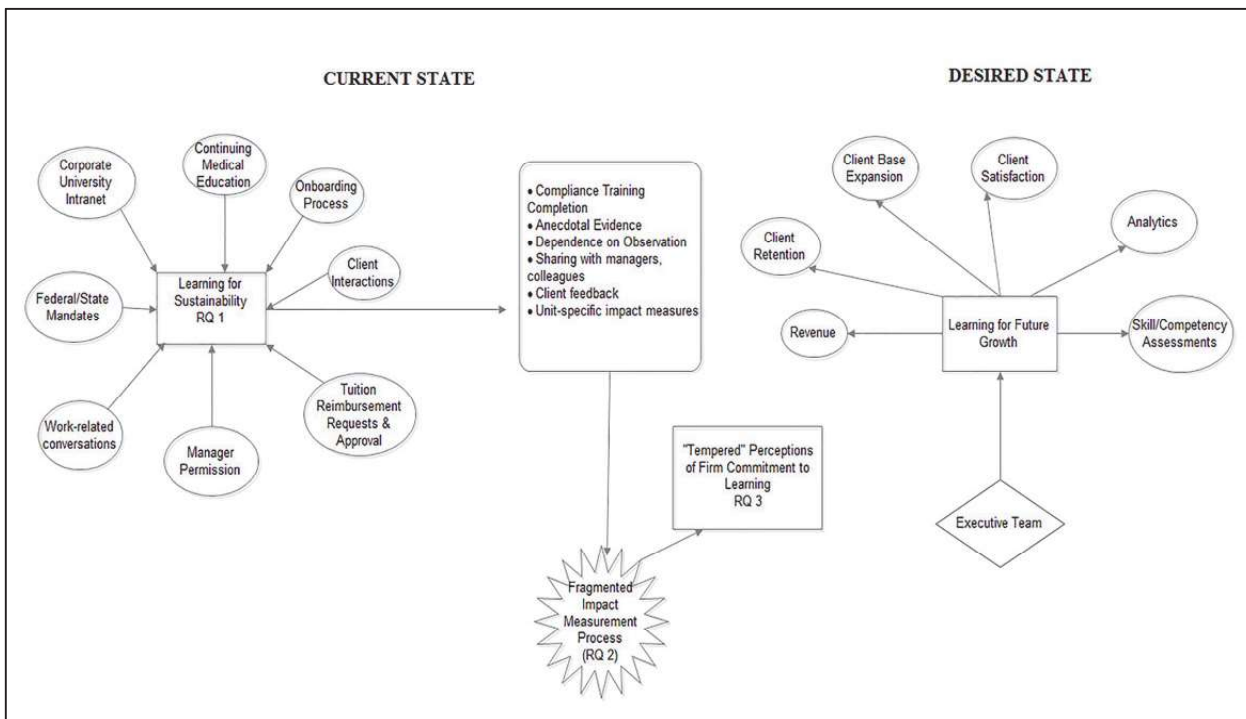
The finding that learning opportunities for the core clinical and operational functions exceeded those for career growth and advancement echoes much of the criticism of leadership development in the healthcare sector. Although the importance of healthcare career planning and leadership development is acknowledged (Edmonstone & Western 2002; Groves 2007; Leatt & Porter 2003; Wilkes & Bartley 2007), our findings yield a mixed picture of successes and best practices within our selected organization.

One research stream that could explain the absence of learning for advancement in the present study is the stream that attributes the lack of development opportunities to insular thinking and a focus on leadership development for selected occupations, such as physicians and nurses (MacPhee et al., 2012; McAlearney, 2006; Spehar et al., 2012). An alternative explanation could be the non-traditional workplace setting in this study and the need to establish credibility on a footing with more traditional settings such as hospitals and community practice centers. With research into the benefits and risks of the worksite healthcare services delivery model just getting underway (Gorman & Miller, 2011; Sherman & Fabius, 2012), the present study adds the perspectives of both clinicians and non-clinicians in affirming the focus on workplace learning for quality service as central to this delivery model, a core requirement that must be met in tandem with efficiency benefits to clients. Uncertainties about the risks associated with this delivery model are further reflected in the finding that the Injury Triage business unit in this study was the unit least able to capitalize on learning opportunities due to time pressures caused by call volume and long shifts, which is consistent with global research on telephone triage (Huibers et al. 2011; Marklund et al., 2007; Purc-Stephenson & Thrasher, 2010).

Integrating learning goals into the performance review process would provide some consistency across business units and functions, so that short- and long-term learning needs could be met for career growth and advancement. There are some studies on best practices for integrating specific goals into the performance review process (Garbett et al. 2007; Lockyer et al. 2011; Needleman et al. 2007). However, these studies tend to be situated in hospital settings and do not explicitly include learning goals.

Our finding that non-managers perceived disparities in field manager decision-making as a barrier to learning beyond the mandatory requirements is consistent with the management practices literature where diverging levels of management support have been found to affect employee motivation to learn and transfer skills learned to the workplace (Beer & Eisenstat 2000; Cromwell & Kolb 2004; Crouse, Doyle, & Young, 2011; Schilling & Kluge 2009). Conversely, the finding that organizational structure served as a barrier to learning appears to contradict the literature. For instance, in their systematic review of the literature to identify measures that affect the implementation of evidence-based health innovations, Chaudoir, Dugan, and Barr. (2013) uncovered little evidence of the impact of structural constructs on innovation, including learning initiatives, being assessed. In their study of nurses working in rural and remote areas of Canada, Penz et al (2007) identified financial constraints and personal demographics as stronger barriers to participation in learning opportunities than structural constraints.

A reason for the discrepancy between our findings and other studies of field manager interactions may be the fact that (a) the field managers in this study were rarely in the same location as their direct reports and (b) the number of direct reports varied by business unit, with some Injury Triage managers having as many as 100 direct reports and one Advanced Practice manager having only four direct reports. The effects of manager span of control on nurses' attitudes and performance in traditional delivery settings have been documented in the literature (Cathcart et al. 2004; Lucas & Spence Laschinger 2008; Shirey 2006). The model generated in this study suggests that those span of control effects also play out in a non-traditional delivery setting like a worksite healthcare services provider but are further exacerbated by geographic distance. A plan for supporting field managers to work from a common and transparent decision-making framework could address perceived disparities in access to learning opportunities. Elements of such a plan might include clearly stated criteria for approving reimbursement requests for longer-term learning needs (Spetz & Adams, 2006) and no/low cost opportunities for employees ineligible for PTO support (Steinbrook, 2008). It may also include mechanisms for recognizing and rewarding field managers for strategic thinking about learning (Swayne, Duncan, & Giner, 2008). Together with consistent and regular communications from the leadership promoting transparency across business units about current clinical and non-clinical performance measures and why those measures are of value at the unit level, a shared understanding can evolve about how these multiple measures demonstrate learning's contribution to overall business performance (Coscarelli, Burk, & Cotter,, 1995; Thatchenkery 2005; Wick, Pollock, & Jefferson, 2010). It would also contribute to a more cohesive view of the organization's commitment to a culture of learning (Ward & McCormack 2000).

LIMITATIONS AND OPPORTUNITIES

The present study was limited to a single worksite healthcare services firm, with the intent of building theory through particularization. The resulting model needs to be tested with other firms whose scope of offerings may differ, so that refinements could be made to the model. Further research should also be conducted among firms at different points in the impact measurement development lifecycle, to better explore the issues and conditions that manifest themselves at differing stages. Moreover, research among firms who have reached the desired state would provide concrete examples of the specific metrics and measures of learning impact and how they may differ from firm to firm.

Nevertheless, the present study has captured significant aspects of business impact measurement in a relatively understudied healthcare delivery model, and the findings represent a starting point for examining the business impact of workplace learning in similar contexts.

Results of this study suggest that practical issues associated with the structure and multi-functional nature of the worksite healthcare services firm can yield disparate definitions of what constitutes learning and what learning opportunities are accessible. The findings also suggest that these differences influenced perspectives on measuring the business impact of learning, contributing to the disconnection between business impact measurement as envisioned by firm executives and impact measurement as practiced in the field. These findings raise the profile of worksite healthcare services firms as a non-traditional healthcare delivery form worthy of further study.

CONCLUSIONS

As economic pressures on the world's healthcare systems continue to increase, new models and approaches to delivering efficient and effective care will evolve. These changes also offer health professionals employment alternatives beyond the traditional hospital and practice centers. However, many of these alternatives must focus on business performance as well as healthcare services. As such, healthcare professionals must learn to perform in workplaces where non-clinical skills and abilities contribute to the advancement of their careers. By integrating non-clinical skills into the continuing education curricula, along with opportunities to gain experiences – real or virtual – in non-traditional healthcare delivery settings, education planners can better assist healthcare professionals in making informed decisions about their employment choices as well as in setting expectations about the role of learning and performance in workplace settings.

DISCLAIMER

The views expressed herein are those of the authors and not necessarily those of the Department of Defense or other Federal Agencies.

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