Human Performance Technology: Benefits in the Workplace

Amanda Philbrick

Instructional Science and Technology, California State University, Monterey Bay

IST524: Instructional Technology

Dr. Sarah Evanick

October 1, 2022

Introduction

Human performance technology (HPT) is the practice of efficiently linking business goals with the people responsible for carrying out those goals (Reiser & Dempsey, 2018). As a model for business, it is highly practical, placing the utmost value on minimizing cost and maximizing benefit with the end goal of valued accomplishment (Reiser & Dempsey, 2018).

The value of systematically applying HPT tenets is easily envisioned for many work environments. Upon reflection, I feel that communication between doctors and nurses in the high-stress, fast-paced environment of a teaching hospital's outpatient clinic could readily benefit from conscious HPT implementation. In such a clinic, fellow trainee physicians are regularly introduced into a new clinic environment and expected to communicate their support needs. Established nurses – already tasked with managing a steady influx of phone calls, emails, and faxes – are regularly interrupted from the flow of virtual care management with urgent demands from trainee physicians. While nursing management might communicate to nursing staff that they are empowered to set boundaries, the inherently hierarchical nature of medicine, lack of management modeling, absence of training, and dearth of performance support tools leaves nurses drowning in an impossible array of tasks. Both in-person and virtual patient care suffers, leading to low patient satisfaction scores and decreased hospital revenue.

Front-End Analysis

Human performance technology, in adhering to general systems theory practices, is always driven by identification of a gap. John Harless, a pioneer in the field, emphasized the need for front-end analysis (Wilmoth et al., 2002). Before diving in with technical innovations and communication matrices, it will be important to complete needs, learner, context, and content analyses (Rothwell et al., 2016). What environmental barriers exist? What available tools might

be reappropriated to streamline effective communication? What knowledge, skills, and motivation levels do nurses and doctors currently possess in relation to communication methods? Which well-respected individuals in the organization might support innovation?

Instructional and Non-Instructional Interventions

The general systems theory upon which HPT is built views organizations as "organic entities with interacting subsystems" (Reiser & Dempsey, p.123). Undertaking HPT is no small task – an entire arsenal of interventions will be necessary. As John Harless identified, though a singular well-designed instruction may lead to optimal performance on tests, actual transfer to the workplace setting often fails. Knowing this, instructional designers must be willing to devote necessary time and resources to developing a "package of necessary responses" (Reiser & Dempsey, p. 124).

HPT interventions might include any number of instructional and non-instructional elements. One non-instructional intervention might be reallocation of labor – specific staff could be assigned to support patient care, while others are tasked purely with virtual care demands. Management might incentive boundary setting in the form of staff call-outs. Leadership could consciously model desired boundary setting techniques in view of nursing staff – congruency between the proposed vision and action should be apparent, and management will need to personify a desired new approach (Kotter, 1995). All such non-instructional interventions should be subject to the same systematic process of analysis, design, development, and production that is applied to instructional interventions (Molenda & Pershing, 2003). Deliberate attention to every step will support reaching desired outcomes.

An HPT intervention in this case might very well be an instructional training on how to effectively communicate. But with efficiency at the forefront, additional provision of

performance support “at the moment of need” would serve the individual and the organization’s goals to optimize performance at the lowest cost (Reiser & Dempsey, p. 133). The greatest drain of an intervention is often time away from work. Perhaps, after a brief well-designed training is provided, integrated support might be built into the communication tools that doctors and nurses already use to communicate with one another. Direct application within the flow of work is the precise engagement we aim to achieve.

Diffusion of Innovation

An important element an instructional designer ought to periodically evaluate when seeking to shift human performance is the current rate of innovation adoption. The Diffusion of Innovations theory offers valuable insight into how we ought to approach convincing different population segments (Robinson, 2009).

If only 5% of a population has adopted a proposed practice, focus should be placed on recruiting the “early adopter” group, gathering enthusiastic individuals to partner in the redevelopment process as leaders themselves. Nurse and physician leaders should be recruited to the effort and empowered to role model. Capitalizing on peer conversations and networks to elicit change is essential. As demonstrated in eight randomized controlled trials, popular opinion leaders steer peer networks (Robinson, 2009). Identifying well-respected individuals in all levels of the organization will support adoption by all. No matter the audience, it should be made clear that the new practice will be advantageous compared to what preceded it, is compatible with existing practices, is easy to use, simple to trial, and provides observable results (Robinson, 2009).

Measurable Outcomes

Because HPT is driven by measurable outcomes, it allows those that practice instructional design to speak the language of business, rendering management communications productive. Human performance technology pioneer John Mager introduced the idea of the criterion element to measure acceptable performance, shifting analysis from instruction to results (Wilmoth et al., 2002). Once the gap has been identified, it is important to link proposed interventions to desired outcomes: improved patient satisfaction scores and increased hospital revenue.

Conclusion

Leaders tasked with orchestrating change will need to move through standard phases – drawing attention to the needed change and its context; allowing employees to engage in revision and buy-in; and finally, locking in commitments with newly established and accepted rules (Strebel, 1996). This process cannot be rushed. Introduction of proposed change ought to be early as possible, and the reasons should be abundantly clear (Flimp Studios, 2017). Patience on the journey is essential as multiple methods are tested, engagement is elicited, progress is tracked, and feedback reinforcement is methodically applied. Reinvention and innovation are no small feats, but with human performance technology practices as a guide, instructional designers are placed in a position to achieve success.

References

Flimp Studios (2017, Oct 5). *7 Ways to Minimise Resistance to Change.* Youtube. https://www.youtube.com/watch?v=NEJzPeyqODo

Kotter, J.P. (1995). Leading Change: Why Transformation Efforts Fail. *Harvard Business Review,* 59-67.

Molenda, M. & Pershing, J.A. (2003). The Strategic Impact Model: An Integrative Approach to Performance Improvement and Instructional Systems Design. *TechTrends, 48*(2), 26-32.

Reiser, R.A. & Dempsey, J.V. (2018). *Trends and Issues in Instructional Design and Technology* (4th ed). Pearson Education, Inc.

Robinson, L. (2009). *Changeology: A Summary of Diffusion of Innovations.* Free Press, New York, 1-7.

Rothwell, W.J., Benscoter, B., King, M., & King, S.B. (2016). *Mastering the Instructional Design Process: A Systematic Approach* (5th ed). Pfeiffer.

Strebel, P. (1996). Why Do Employees Resist Change? *Harvard Business Review,* 86-92.

Wilmoth, F.S., Prigmore, C., & Bray, M. (2002) HPT Models: An Overview of the Major Models in the Field. *Performance Improvement, 41*(8), 16-24.