



Stewardship

by Jim Hill, CPT

Drip, drip, drip....

Hear that? It's the sound of money leaking out of your organization.

It happens every day. Millions of dollars, yen, and euros. The problem is so extensive that it barely gets a raised eyebrow. It's just the way things work.

Where do many of these drips come from? Easy—from the departments responsible for delivering performance improvement solutions.

Why? Also easy. Because those departments often focus on the wrong results—happiness, activity, and organizational size. You've seen the symptoms.

- **Happiness:** "Hey, my course got a student rating of 4.6 out of 5!"
- **Activity:** "I know it's not the right solution, but that's what the VP wants."
- **Organizational Size:** "Yep. This year they increased my budget by \$2 million. I must be a player."

When a company is flush with money and revenue is pouring in, it's easy to accept—or at least overlook—these comments. We want people to like us. That's not a bad thing. But often it gets in the way of the end results required for organizational health. Also, in a kind of a locker room approach, people often associate organizational power to the size of one's resources. The more money and headcount managers have, reasoning goes, the more important they must be.

Making Our Profession Shine

Sometimes the money drips overtly, other times, less so. But the culprits are always the same: undefined, ill-advised, and poorly selected solutions. The leaking can deflate an organization. Within many industries over the last three years, companies have been clawing for every dollar, but the internal leaks persist. When money is tight, revenue is down, and costs are called into question; this behavior causes severe pain, particularly when several managers are doing it across a company. The behavior is tough to stop because, by that time, organizational norms have been established and the activities have become ingrained as usual ones. We know that spending because we have, or buying because we want, needs to halt. Yet there's no method for stopping it.

As performance leaders we need to pause and regroup. If we are a party to these “performance improvement” approaches, we are not helping. In fact, with little argument, it’s clear that if we engage in the above monologues, we are damaging our profession, not to mention our organizational and personal reputations.

We often hear that people are our greatest resource. But when layoffs occur, it’s likely that many of the first people to disappear are the trainers and knowledge managers. This isn’t funny. It’s happened many times over the past three years—even multiple times in the same organizations. Unfortunately, these internal organizations are often well known for their leakage. Still, their reductions only exacerbate the leaking as remaining managers redouble their efforts to create happiness and activity in an attempt to show value.

Someday, hopefully soon, we will come to realize that we are the *stewards* of our organizations’ resources. We will cringe when managers refer to “their people,” “their organizations,” or “their budgets.” Those assets are not theirs. They belong to the shareholders. As resource managers, our sole responsibility is to create additional wealth with the assets we’ve been provided and, as stewards, we must focus on results. If we don’t, the assets entrusted to our care will be taken back. And us? We’ll be gone.

The Conversation We Need to Start

At this precise economic moment there is a desperate need for a method of having a performance-oriented conversation with senior leaders that they find refreshing—a conversation in which the initiator can say, “Hey boss, there’s a methodology that can help us with our core issues—and save us money.” If the speaker of that promise is even marginally regarded, the boss’s response will almost certainly be, “Tell me more.” That response ensures we are on the path of stewardship.

Where’s the Return on Investment?

We know from a wide range of studies that most performance problems have their roots in organizational defects, rather than in problems with individuals. Many researchers suggest that 85% of issues are at the organizational level. When we align the causal data with the behavior engineering model, we see similar indications.

We also know that each year Fortune 200 companies spend between \$300 and \$900 million on training. Government and military organizations spend far more. Of all that training, typically less than 10% transfers to actual on-the-job performance, and in some cases, students on average, forget more than 80% of presented material within just nine weeks. In any other field, that type of return would be grounds for

termination. For some reason—probably because training providers do a good job of responding to managerial wants—we accept the poor return in order to get the immediate gratification of seeing people sitting in classrooms.

Developing Three Abilities

If we want to increase our value to our organizations as performance improvement professionals, we need the ability to do three things as organizational physicians:

1. Figure out what’s causing pain.
2. Write accurate prescriptions.
3. Effectively communicate in a way that causes a follow-through reaction.

We often hear that people are our greatest resource. But when layoffs occur, it’s likely that many of the first people to disappear are the trainers and knowledge managers.

Performance technologists have unique approaches that tend to work when we diagnose correctly and our recommended prescriptions are followed. In fact, our solutions are so effective that as we fix an organization’s performance ills, we are likely to reduce their training, process and general intervention budgets between 30% and 50%.

Giving Up Budget

Some readers just thought, “Uh-oh. Why would I want to give up my budget?”

From one perspective, you may not need to give up budget or people. If you are a performance improvement professional, you are likely much broader and deeper than a single intervention. By telling your organizational leadership that you can help fix critical issues, you are also taking responsibility for doing it. Rather than spend an entire budget on training that produces little, you will have the power to deploy multiple solutions that will create massive impact. You will also have the power to say no to managerial requests for activities that either won’t work or aren’t a high enough priority.

Still, if giving up resources is the right thing to do, you ought to do it. The fact is that unless you are a sole proprietor or the single shareholder of a company, no organization is “yours.” You are a steward—working on behalf of the shareholders and at the pleasure of senior leadership or the board of directors.

Opportunistic Consultants

Another contributing cause of financial leakage is predatory, or opportunistic, consultants: those who mask themselves as performance consultants but, at the end of the day, are actually hawking some other money maker such as generic training, process development, or organizational redesign. They often offer “custom solutions,” which mostly means changing the name of the client on the cover page of the project plan. Cynical? Maybe. Accurate? Take a look at some of your recent custom work on leadership, team building, and competencies. Then ask the provider for samples of similar work from other clients.

The sad part of this is that there are few pure “performance consultancies,” or those whose main capability is their analytical capability. As a result, companies that need help cry out to a wide range of performance improvement organizations that often have, in actual fact, a single solution with which they are waiting to pounce. The client receives a review of its problems masked as analysis and is then informed that its primary “need” just happens to be the sole solution offered by the consulting organization. Drip, drip, drip...

The Medical Field as Exemplar

We have an example of a respected analysis capability that works—our medical counterparts. They are performance improvement consultants. Within their ranks, general practitioners mostly analyze, recommend, refer, and prescribe basic medication. They also dispense certain medications, although these tend to be low risk and topical. Specialists reconfirm analysis, prescribe more serious medications, supervise treatments, and monitor progress. Some specialists also perform surgery. Pharmacists dispense prescriptions. They do not analyze the situation, but they know what amounts and combinations work. If there seems to be a problem with the prescription, they check with the prescriber, not the patient.

Like a general practitioner, a pure performance analysis consultant provides benefit to the organizational steward as an honest broker, an extra set of eyes, and as an in-depth reviewer. On behalf of the steward, these consultants analyze problems, looking for the root cause of performance ailments. When they find ailments, they report them and then recommend the right solutions. They probably don't have the capability to design and develop these solutions, but they make the recommendations anyway, knowing they are the right things to do. At that point, the patient knows what should be done and has the ability to choose a specialist or a pharmacist who can implement the solution.

Living by a Code

Over the past few years, the board and membership of the International Society for Performance Improvement have

Guidelines—Consulting and Audit Canada

Conduct as Professionals Providing Services to

External Clients: [T]he key characteristics of a professional relationship with clients include being qualified to do the work, serving the best interests of the client, [and] being objective in our judgments....

Qualifications: [A]ccept only those assignments that we are qualified to carry out by virtue of our knowledge, experience, skills, and abilities.

Client Interest: [A]ccept only those assignments that we believe to be of real benefit to the client.

worked hard to develop a practical Code of Ethics. Those who have recently completed their certification applications are familiar with this Code of Ethics. While this set of ethics works, once in a while it's valuable to see what other professional societies expect of their members. In addition to the medical code of ethics, one should also consider some of the guidelines offered by Consulting and Audit Canada, an organization dedicated to improving public sector management and operations (see sidebar above).

Serving Whose Needs?

A few months ago, I met the CEO of a publicly traded company who said he had strategic planning problems. Over the past two years, revenues had significantly declined. Morale was low due to the severe personnel reductions necessary to keep the company near profitability. I visited his organization and over a two-hour conversation he laid out in great detail his vision and the future needs of the company. I asked him if his leadership team knew everything that he had just shared with me. He simply replied, “no.”

Regardless of his answer, this would have been a great opportunity to sell some strategic planning. A consultant could initiate a few executive team meetings, throw in some Myers-Briggs stuff and a few team-building exercises, come up with a value proposition, and offer some Big Rules.

Wow! Combined, it was an easy \$100K-\$200K opportunity. I could have even asked the team to attest to the value of my work and gotten a little closer to my CPT re-certification requirements.

The problem, however, was not a lack of strategy. It was a lack of sales. When the top 10 global sales leaders assembled soon after, I was fortunate enough to receive an invitation to the meeting. Each regional leader provided a 30-minute summary of his or her recent results and plans for the

upcoming quarter. Except for a single manager, no one used a number—this in a sales update! It was fairly evident that no one had a goal or was being measured against a definitive goal. Customers had recently purchased a “substantial amount” of product. Another customer was “likely” to purchase a “large quantity” in the next “few months.”

As it turned out, the issue was caused by a lack of expectations and feedback, plus a lack of a mechanism for tracking progress. After some additional work developing a goal-setting method, a forecasting model, and a tracking system, they began to see improvement. Sales increased and within eight months the company’s stock had more than doubled.

Doing What’s Right—Even Delivering Painful News

As adjunct stewards of organizational resources, performance consultants must be able to deliver bad news and tough love. If we can’t truly fix the problem, or if we can’t look the client in the eye and give the diagnosis—no matter how painful—we’re in the wrong field and we are doing harm. For our profession to succeed, grow, and excel, we must improve our ability to render truth.

A few years ago, my dad lay in the hospital, once again felled by a cancer that he could not shake. He was a strong guy, a huge guy, yet he was not winning this fight. Over the previous few years he had been in and out of the hospital. The doctors had taken various small chunks of his body, and applied the chemical and radiological regimens typical for managing the disease. One winter day, I received a phone call and was told to get home quickly. This time it was bad.

After traveling 2,000 miles, I got there the next day. My dad was conscious and very aware of his surroundings. He was on a respirator and couldn’t talk, but he ably communicated by weakly jotting a few notes on a scratch pad. All of the family members were there, milling around as folks tend to do in situations where they want to do something but there’s nothing that can be done.

I went to meet the specialist. The doctor described the size of the mass, which was huge, and its location, which as difficult to access. Inoperable. He went on to say that once off the respirator, the end of my father’s life would likely come in a matter of hours. I asked how long we could keep him on the machine and whether more time and more radiation would help. Speaking in non-technical terms that I would understand, the doctor said, “More radiation won’t help and, as for the respirator, you can basically keep him on it forever. The question you really should be asking is what quality of life you want for him.”

It was my turn to deliver bad news, first to my mom and brothers who were waiting for me in the hall, then to my

dad. I went in to his room. He was alone, listening to some music. “Dad, we need to take you off the machine,” I said.

He knew exactly what I was telling him. He and my mom had some private time together and then the medical staff did what they needed to do. In less than 18 hours, he passed quietly away.

The doctor had done precisely what was required. He had told the hard truth, outlined the options, and presented likely outcomes. My dad had a great insurance policy. Surely the hospital and the doctor could have milked it for a little more. But that was not the right thing to do. As my dad lay still, doctors, nurses, and family all stood over him, each with teary eyes and muffled sobs. This was a tough decision. No one liked the outcome, but it had been the right thing to do.

Performance Technologist as Physician

As we continue to build our profession, we are going to have to step up to the plate. It’s easy to be the organizational physician when the patient has a cold. It’s a lot harder when we find a more serious ailment. Who is going to break the news? Who is going to prescribe the aggressive regimen required for improvement? We will. We must. It is our duty. And what if we don’t have the skill to fix the problem? Are we professional enough to make the hand-off to those who can? We must. It is our duty as stewards.

Diagnosis is our first step. In the medical profession there are analytical methods that consistently lead to the correct identification of the problem. Within our own profession, we must stick to the science. Haphazard analysis harms our patients and our profession.

Once the tests are complete and the answers are reviewed, physicians consult a book of treatments and issue the recommended prescription. Only in the case of malpractice do we hear of physicians who defy the diagnosis and institute their own unqualified treatments. It virtually never happens. In the case of surgery, professionals look for the least invasive method. They don’t cut because they can; they cut because it’s necessary.

For problems to get fixed, there needs to be a combined effort between the physician and the patient. However, patient wants and their long-term noncompliance often disrupt the treatment.

Wants. Some patients want certain things from their doctors. In some cases, they may want a certain prescription. In other cases, they may desire certain surgeries although no health issues are at stake. Doctors are not swayed by these requests. They won’t work. As for elective surgery, there are, indeed, certain physicians who set up practices to respond

to cosmetic requests, but the large majority of their work is unnecessary and very costly.

As attending organizational physicians, we can easily prescribe the unnecessary. But we shouldn't, for two reasons: First, we have professional reputations that we don't want to tarnish with inappropriate treatments. Second, most patients trust our judgment and, rather than having them suggest solutions, we should coach them to seek us out for corrective action and recommendations. It's not easy the first time. Organizational patients have been burned too many times. But this is the path we must take as we grow our organizational health care practices.

Noncompliance. Physicians still run the risk of their treatments being ineffective. Why? According to the American Medical Association, the major reason is patient noncompliance. In the medical field, noncompliance causes more than 125,000 deaths annually in the United States and leads to upwards of 25% of all nursing home admissions. That's 380,000 patients at a cost of more than \$31.3 billion. In addition, it is estimated that 10% of all U.S. hospital admissions are due to noncompliance—more than 3.5 million patients at a cost of more than \$15 billion (Schering Report IX, 1987)!

We must help our organizational patients complete their treatments and remain on the alert for situations in which they are not following the prescribed regimen. If we deliver and depart, we're not helping. Remaining a part of the oversight team, even if we are not the solution provider, helps ensure the organization completes the prescription.

Saying "No"

To No Return. We all have examples of where a lack of analysis led to huge expense and no return. I'm reminded of the invitation I received from one of the world's largest technology companies to a demonstration of its new knowledge management system. This company's leadership expected that each of its 120,000 employees would register in the new third-party system and provide a detailed summary of their skills and knowledge.

The thought for this particular company was that the collected information could be accessed when new project teams were being formed. The hope was that this would support the creation of highly productive teams of motivated and knowledgeable participants. The reality was that the information provided had more to do with hobbies than with professional abilities. So, after investing millions of dollars, only about 8,500 employees registered and the system was found to be absolutely magnificent...for forming bowling teams. This is not the work of stewardship.

Consider that, although, according to a report by the Cambridge Information Network (1999) and another related

report by KPMG (2000), virtually no companies think that their knowledge management investments have been successful, and about 36% label them clear failures. Yet money often pours into these systems, despite the few results produced.

To New-Age Medicine. To a large degree, managerial wants are very similar to the wants of medical patients. They drive the development of new-age treatments. Within the medical industry, alternative care is booming. However, much like new age performance consulting, medical research doesn't show much positive in the way of results. In a much-cited 1990 study at the Harvard Medical School, later published in the *New England Journal of Medicine*, researchers found that one in three Americans had used some form of alternative therapy during the previous year. A National Institutes of Health report gave similarly dramatic information. In 1992 alone, 425 million visits were made to alternative health practitioners, compared to 388 million visits to conventional physicians. What's more, there were more visits to chiropractors, acupuncturists, homeopaths, and herbalists than to all primary care physicians combined (Your Family's Health, 2003).

Even more impressive is that the cost of all those trips to alternative caregivers—an estimated \$14 billion—was mostly paid out of pocket, because those treatments tend not to be covered by insurance plans.

Not to be deprived of this revenue opportunity, some traditional physicians are adding acupuncture, herbal and botanical remedies, and various mind and body techniques to their list of services. At the same time, they are accusing alternative practitioners of selling unscientific and ineffective therapies.

Great marketing, for certain, but why are these solutions popular? Three reasons. The first is that some pharmacological treatments come with unwanted side effects—by fixing one part of the system, something else is harmed. There's a lack of a systemic solution. Second, patients think they know better. They believe there's a better treatment; all they have to do is find it. Third, traditional practitioners don't have the time to really know their patients. So, even though the doctor may not fix the patient's problems, at least the patient feels that someone is listening. As performance professionals, we need to remain on guard against similar phenomena.

We Cannot Bend

Regardless of patient or organization wants, we cannot bend to prescribe what organizational patients truly require. As organizational stewards we subscribe to a higher order. We cannot advocate or support patient wants or their use of untested, untried solutions. Our best defenses are accurate diagnoses, precise prescriptions, and the ability to instill confidence in the organizational leaders who must keep

their teams on track. When we do these three things, organizational productivity will skyrocket, costs will plummet, and our profession will thrive. 🏔️

References

Cambridge Information Network. (1999). *The knowledge paradox: How to manage your most strategic asset.*

KPMG. (2000). *Knowledge management research report 2000.* London: Author.

Schering Report IX. (1987). *The forgetful patient: The high cost of improper patient compliance.* Falls Church, VA: Healthcare Compliance Packaging Council.

Your Family's Health. (2003). Can mainstream medicine and alternative therapies coexist? [On-line]. Available: http://www.yourfamilyhealth.com/alternative_medicine/fIRST_do_no_harm/

Related Readings

Gupta, O., Pike, S., & Roos, G. (2002, July). *Evaluating intellectual capital and measuring knowledge management*

effectiveness. Presented at PMA Performance Measurement Conference, Boston, MA.

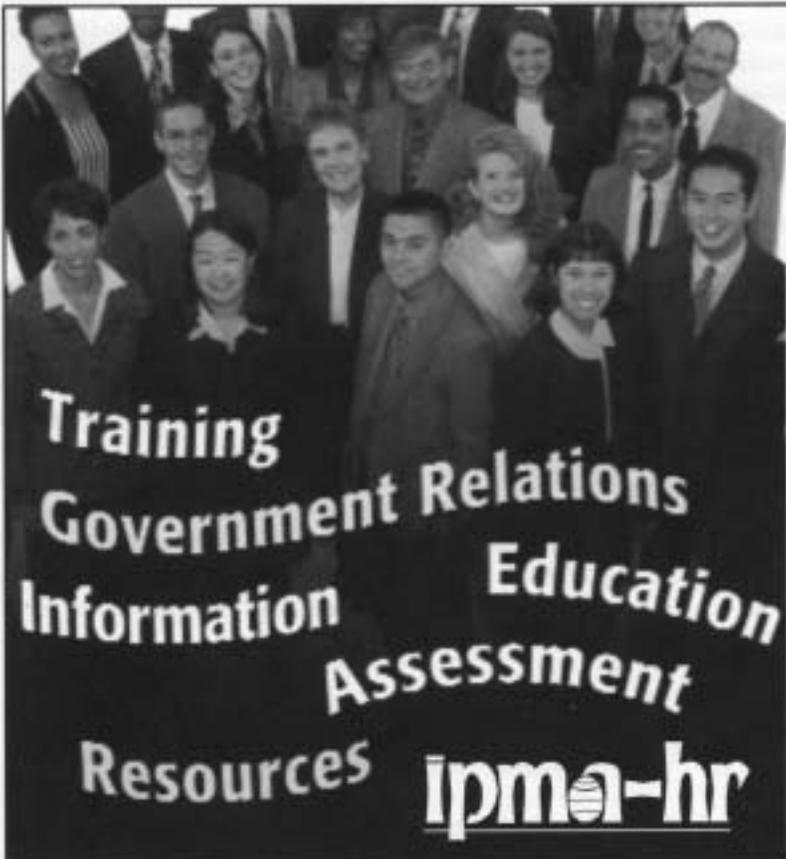
Research Institute of America. (1990). *Corporate drivers of e-learning* [On-line]. Available: <http://www.forbes.com/specialsections/elearning/e-03.htm#c>

Smith, D. (1989, February). Compliance packaging: A patient education tool. *American Pharmacy, NS29(2).*

Standberg, L.R. (1984). Drugs as a reason for nursing home admissions. *American Health Care Association Journal, 10, 20.*

Oregon Department of Human Resources (1981). *A study of long-term care in Oregon with emphasis on the elderly.* Salem, OR: Author.

Jim Hill is the most recent past president of ISPI and a certified performance technologist who has achieved success in the field of human performance technology as a Marine officer, corporate executive, and entrepreneur. An active member of ISPI since 1989, he has been featured in Sales and Marketing Management and Training magazines for his performance improvement innovations. Jim may be reached at jim.hill@proofpoint.net.



IPMA-HR is the leading organization addressing the needs of public sector human resources professionals.

By offering the tools, resources, and information unique to the public sector, IPMA-HR works to enhance the image of the human resources professional through ongoing professional, personal and organizational development.

For more information contact IPMA-HR at 703-549-7100, or visit www.ipma-hr.org