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Identifying intangible assets in interprofessional healthcare organizations: feasibility of an asset inventory

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\section*{ABSTRACT}
Healthcare systems increasingly use business models that focus on tangible assets such as finances and facilities. Yet \textit{intangible} assets, such as values, relationships and human capital, remain critical for understanding the worth of interprofessional healthcare education and collaboration. We implemented a novel interprofessional collaborative pilot exercise to explore the feasibility and usefulness of an Asset Inventory—using KJ methodology and an appreciative inquiry perspective—to identify and better understand intangible assets and their value in interprofessional healthcare education/training organizations, for planning, and as a first step toward informing strategic decision-making. Twenty-eight faculty physicians, nurses, psychosocial and family faculty, educators, health services researchers and administrative staff participated. Participants identified intangible assets in five categories: Philosophy/Mission, Practice/Practical Strategies, Human Capital, Scholarship/Research Productivity, and Partnerships. Participants reported a greater understanding of intangible assets, and increased enthusiasm, organizational confidence, and stakeholder ownership for healthcare education programs. While this study is preliminary, the Asset Inventory may prove useful to enhance understanding of the importance of intangible assets within interprofessional healthcare education/training organizations, to inform planning and decision-making, to identify and foster interprofessional collaborative capacity across clinical and training settings, and to leverage intangible assets in today’s rapidly changing business-focused healthcare systems.

\section*{Introduction}
Healthcare systems increasingly rely on business models and productivity metrics, yet intangible assets remain critical to healthcare education/training organizations—e.g., academic healthcare centres, hospitals, medical/health professions schools, and practice settings. Corporate healthcare models emphasize “efficiency” with increasing emphasis on technology and throughput. Assets traditionally measured include tangible commodities such as physical plant, finances, and profits.

However, intangible assets such as philosophy, vision, practice contributions, partnerships, values (Rider et al., 2014), research, human and intellectual capital (Evans, Brown, & Baker, 2015), are essential to the provision of quality healthcare education, interprofessional collaboration, and institutional success. Intangible assets are more difficult to identify and measure than traditional business assets.

Organizational strategic planning and growth hinge on effectively leveraging intangible assets such as human and intellectual capital, yet few healthcare organizations and institutions explicitly identify and manage their intangible assets or systematically utilize these to improve performance (Evans et al., 2015). We set out to explore the feasibility and usefulness of an Asset Inventory using KJ methodology (Kawakita, 1991; Kunifuji, 2016) to identify and better understand intangible assets and their value in an interprofessional healthcare education/training organization by creating an Asset Inventory with the goal of using it for planning and as a first step toward informing strategic decision-making.

\section*{Background and innovation}
The KJ Method (Kawakita, 1991; Kunifuji, 2016) is widely used in Japan and elsewhere for creative thinking, systematic problem solving and quality management. Unlike top-down
problem-solving methods, the KJ Method is a bottom-up tool that gathers large amounts of data (e.g., ideas, issues) and organizes it, through steps of divergent and convergent thinking, into groupings based on natural relationships (Kawakita, 1991; Kunifufu, 2016). The KJ Method promotes creative thinking, valuing of different perspectives, and encourages group ownership of actions.

The aim of this pilot interprofessional collaborative learning exercise was to assess the use and feasibility of developing an Asset Inventory, by combining the KJ Method and an appreciative inquiry (AI) perspective, to help interprofessional healthcare education/training organizations better understand their value and intangible assets. We envision that such an Asset Inventory may help organizations to leverage their intangible assets in today’s rapidly changing business-focused healthcare systems.

Methods

Setting

We developed the Asset Inventory learning exercise and piloted it in an interprofessional healthcare education/training organization that conducts interprofessional, experiential educational programs and interventions that address relational competence, communication skills, interprofessional collaboration, and professionalism across a wide range of healthcare settings. The pedagogical approach of the organization, Institute for Professionalism and Ethical Practice at Boston Children’s Hospital, Harvard Medical School, is based on interprofessional relational learning and reflective practice (Browning, Meyer, Truog, & Solomon, 2007).

Process

Senior faculty clinicians (ER, MC, EM) developed the Asset Inventory learning exercise by adapting the KJ Method and appreciative inquiry concepts (see online Table 1—Refer Online supplementary). Twenty-eight interprofessional faculty, colleagues and staff participated in the Asset Inventory exercise during a faculty retreat in June 2015.

Before the retreat, participants were asked to reflect on their experience with the organization and its intangible assets. The question for focus: What are the organization’s intangible assets? Flip chart sheets were mounted on the walls, one for each of several suggested asset categories (i.e., mission, human capital, partnerships and philosophy) to start the exercise. Following an introduction, participants brainstormed in small groups of 2 to 3 individuals, identifying and recording each asset on a ‘sticky note’. All attendees then participated in an interactive large group session where each asset was read aloud and discussed, similar assets were placed together, and the entire group determined best-fit categories. Through a qualitative process using iterative consensus, additional asset categories were determined. Assets and categories were then reviewed, combined and redistributed based on group consensus. Following the retreat, the Asset Inventory results were prepared as a written document, and then shared with participants for feedback and further refinement. Final fine-tuning was discussed by senior clinician participants and agreed on by consensus.

Ethical approval

The Boston Children’s Hospital IRB was consulted. They considered this an educational quality improvement exercise and determined IRB approval was not necessary.

Results

Participants included: 8 physicians (29%), 6 psychosocial faculty (social workers, psychologists) (21%), 4 nurses (14%), 4 educators (14%), 3 other healthcare professionals (medical student, health service researchers) (11%), and 3 administrative staff (11%). Seven in the above categories were family faculty members. Family faculty, parents of children with special healthcare needs, are members of our interprofessional faculty who role model interprofessional and relationship-centred partnership with clinicians (Browning et al., 2007). Participants came from both within and outside of the institution; all were affiliated with the organization.

Participants arranged the organization’s intangible assets into five categories: Philosophy and Mission, Practice and Practical Strategies, Human Capital, Scholarship/Research Productivity, and Partnerships (Figure 1).

Key assets that stood out during group reflections included: articulating and connecting values to the organization’s work; willingness to take risks when developing programs; innovative teaching and learning approaches; the organization’s reputation for embracing difficult topics; scholarship; and partnerships.

Through this collaborative Asset Inventory exercise, participants elucidated intangible assets that could contribute to the organization’s growth and success. Participants discussed new ideas and opportunities, demonstrated openness to others’ perspectives, and articulated increased enthusiasm about the organization, organizational confidence, and stakeholder ownership for the organization’s future.

Through identifying the organization’s intangible assets, participants noted that growth does not necessarily require looking externally for resources, but rather recognizing and marshalling the skills and assets the organization possesses as a whole. They identified previously unknown skills and untapped knowledge among participants that could lead to growth in new areas and improve current programs and practices.

Discussion

We sought to explore the use and feasibility of developing an Asset Inventory to help interprofessional healthcare education and training organizations better understand their value and intangible assets. Our interprofessional collaborative learning exercise combined the strengths of appreciative inquiry (AI)—focus on the ‘positive’, enhanced organizational awareness, creativity, mutual respect, and relationship building (Dematteo & Reeves, 2011)—with the KJ tools of divergent and convergent thinking to collaboratively identify and categorize organizational assets and facilitate group solidarity.
From our experience, the KJ Method provided a broader, more organizationally focused exercise than an AI approach alone.

Dematteo and Reeves (2011) critiqued reliance on AI as a tool of change in healthcare noting, “the use of AI can overlook a number of structural factors, which will ultimately limit its ability to actually secure meaningful and lasting change within health care” (p. 203). Our work may potentially extend the value of appreciative inquiry by employing the KJ Method to focus on the organization or system itself to better delineate the role of intangible assets in healthcare education/training organizations.

While the current literature precludes definitive conclusions about the effect of interprofessional learning and collaboration on organizational and behavioural changes (Brashers, Phillips, Malpass, & Owen, 2015), some evidence supports interprofessional learning as a way to strengthen attitudes, knowledge and collaborative skills (Reeves et al., 2016). Our interprofessional learning team also included participants with diverse expertise, including health service researchers and those involved in curriculum development and teaching across the interprofessional education (IPE) continuum. Rather than focusing on specific IPE courses or teams, we took a broader focus of examining organizational factors in a health system. Although our results are preliminary, we identified systems aspects—Philosophy and Mission, Practice and Practical Strategies, Human Capital, Scholarship/Research Productivity, and Partnerships—that impact an IPE organization.

While healthcare institutions must attend to tangible assets, we believe an equal emphasis on intangible assets is essential. Intangible assets remain critical to understanding and articulating the worth of interprofessional healthcare education/training programs. Quality healthcare includes human factors, continuous learning, and knowledge development. It remains interpersonal and relational, framed by core values (Rider et al., 2014), everyday ethics, professionalism, and capacities for relationship-centred care.

Limitations of this pilot study include carrying out our collaborative interprofessional exercise at one large academic medical centre, and participants’ self-reporting their experience with the exercise. Most participants came from various departments within the institution and some were based at other institutions, yet all had a role in the organization and were involved in its interprofessional programs. We note the preliminary nature of this work, and encourage others to build on this initial effort. We suggest further study to determine the efficacy and usefulness of this Asset Inventory/KJ Method at other institutions and in other interprofessional and single-profession settings.
We plan to repeat the Asset Inventory exercise periodically, as our evolving Asset Inventory may provide a helpful benchmark, enhance overall understanding of our programs and strengths, and help to guide our strategic decision-making as different opportunities arise. Repeating the Asset Inventory will also facilitate a review of the organization’s use of these results in making meaningful change in organizational priorities and intangible asset management.

Concluding comments

Healthcare systems increasingly rely on business models and productivity metrics, and focus on tangible assets such as facilities and profits. However, intangible assets such as values, partnerships, human capital and others remain indispensable to the success of healthcare education/training organizations. We describe an innovative interprofessional learning exercise, adapted from the KJ Method and appreciative inquiry concepts, that was used to identify and elucidate the intangible assets of an interprofessional education/training organization and to create an Asset Inventory. While preliminary, our results suggest that this approach could provide a means to identify and nurture interprofessional collaboration and collective capacity and to inform strategic growth within a variety of healthcare institutions and training organizations. Engaging in the process of Asset Inventories may help to increase healthcare organizations’ attention to the intangible assets that are fundamental to high-quality healthcare education and practice.

Acknowledgments

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Disclosure Statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

Ethical approval

The Boston Children’s Hospital IRB was consulted. They considered this an educational quality improvement exercise and determined IRB approval was not necessary.

Previous presentations

Preliminary findings were presented as an oral abstract at the American Academy on Communication in Healthcare Research Forum, New Haven, CT, June 2016, and at the National Academies of Practice 2017 Annual Meeting & Forum, Philadelphia, PA, March 2017.

References


**Supplementary Online Material for:**

Table 1. Developing an Asset Inventory: Learning exercise steps and aims adapted from the KJ Method

<table>
<thead>
<tr>
<th>Steps and Aims*</th>
<th>KJ Method*</th>
<th>Adaptation and Implementation</th>
</tr>
</thead>
</table>
| **Determine topic for study, problem solving, or idea generation** | Consider: What are you trying to achieve?  
State question for focus. | • Goal: To explore the organization’s intangible assets and their value by creating an Asset Inventory, with the goal of using it to guide strategic directions and decision-making, and to gain a greater understanding of the interprofessional healthcare education/training organization  
• Question for focus: *What are the organization’s intangible assets?* |
| **Bring group together** | Include people from different parts of organization; varied perspectives | • Diverse group: interprofessional, varied roles and level of experience, clinicians from 4 professions, educators, health services researchers, leadership team, faculty, affiliates, administrative staff, project managers, trainees/interns, and individuals from several institutions |
| **Generate ideas “Label making”** | Relevant facts and information is written on individual cards or “sticky notes” – one thought, idea, fact, or concept per card.  
General emphasis is that facts and ideas are important, relevant, and verifiable. | • Pre-work: Participants asked to think about and reflect on the focus question prior to the retreat.  
• Participants encouraged to write down all ideas that come to mind – one idea per ‘sticky note’.  
• Participants worked in dyads and groups of 3 to generate ideas.  
• Used overlying concept of appreciative inquiry – identifying the positive, ‘good’, rather than problems. |
<p>| <strong>Display ideas</strong> | Cards are grouped together; categories identified and named | • Ideas presented to the large group and discussed. |</p>
<table>
<thead>
<tr>
<th>Step Description</th>
<th>Description</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Group similar items.</td>
<td>• Similar ideas grouped together. New ideas added.</td>
<td>• Open discussion during this step.</td>
</tr>
<tr>
<td>Sort ideas into related groups</td>
<td>Group redistributes cards to create a better fit; sorting continues until consensus is reached.</td>
<td>• Intangible assets were sorted and re-sorted into “buckets”/categories via open discussion.</td>
</tr>
<tr>
<td>&quot;Label grouping”</td>
<td>This step is traditionally done in silence, without discussion.</td>
<td>• Expert facilitation was used to encourage all viewpoints to be heard.</td>
</tr>
<tr>
<td>Create category (“header”) names</td>
<td>Name of category (“header”) should capture the link among ideas on the cards.</td>
<td>• We started with several general categories. These were revised/changed and new categories were added during the process.</td>
</tr>
<tr>
<td>&quot;Group label naming”</td>
<td>A header summarizes the facts in a group.</td>
<td>• Group discussed categories to gain understanding about how they related to each other and the rationale for each grouping.</td>
</tr>
<tr>
<td>Draw finished diagram / chart</td>
<td>Make chart of groups and sub-groups, arranged spatially. Can show with symbols the relationships between labels, groups (i.e., cause and effect, contradiction, interdependence, correlation, etc.)</td>
<td>• Assets identified were placed in categories on walls of room – one flip chart paper per category.</td>
</tr>
<tr>
<td>“Chart making”</td>
<td></td>
<td>• Categories and sub-categories were reviewed and discussed, followed by a facilitated group discussion, and sharing of reflections and insights on the process and categories.</td>
</tr>
<tr>
<td>“Explanation”</td>
<td>Explain chart verbally and then in writing to help participants understand interrelationships among the parts of problem.</td>
<td>• Categories and sub-categories of invisible assets were transferred to a written document after the retreat. The document was shared with participants for feedback and further refinement.</td>
</tr>
<tr>
<td></td>
<td>Vote on most important groups</td>
<td>• Final themes discussed by senior clinicians and agreed on by consensus.</td>
</tr>
</tbody>
</table>

*Adapted from Kawakita (1991) and Kunifuji (2016).