



Developing and Implementing a Career Ladder Program

By Michelle Wall, MS, CRA, RT(R)

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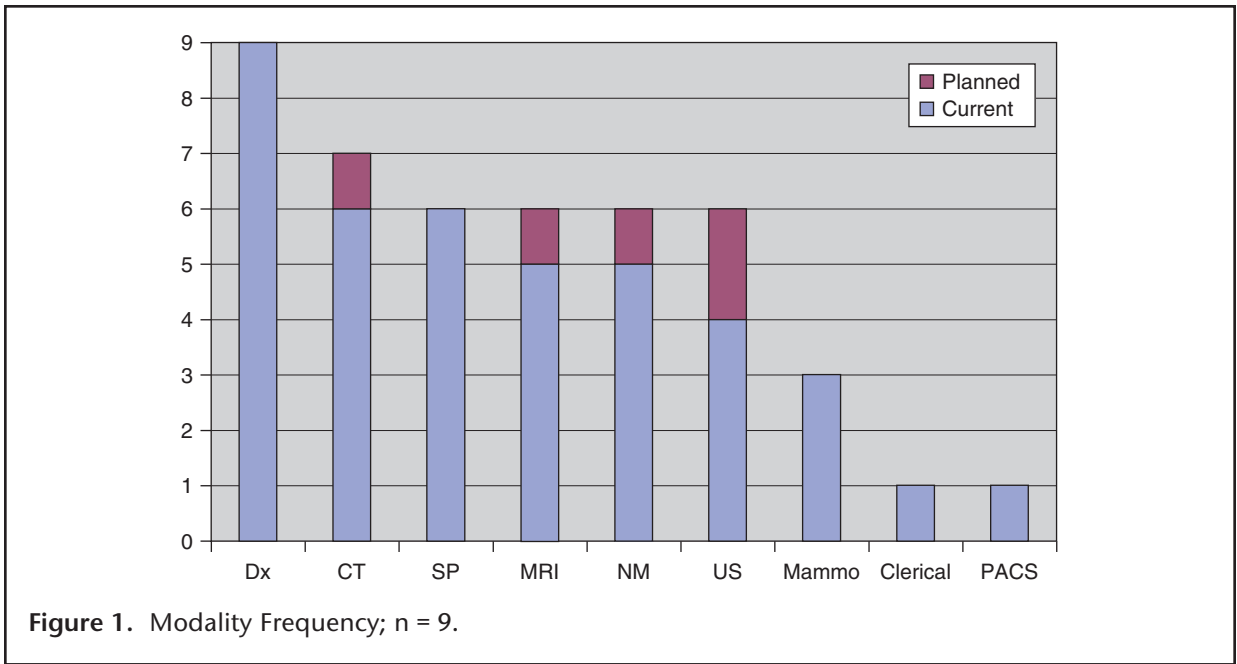
EXECUTIVE

SUMMARY

- A career ladder program is a formal management tool used not only by managers looking to recognize and retain employees, but also by employees seeking growth opportunities.
- A career ladder program involves careful development, frequent and effective communication during implementation, and activities focused on measuring program effectiveness.
- Career ladders are a way to increase productivity and staff versatility; improve morale, clinical quality, and staff satisfaction; reduce turnover; promote professional growth and job enrichment; and improve patient care.

A career ladder is a system of employee salary progression that provides for advancement through a set of graded steps or levels.¹ Progression on the ladder occurs in relation to achievement. According to Peterson,² the first model for clinical advancement was proposed in 1972 by Zimmer.³ The goal of this first career ladder was to increase retention and bring higher levels of expertise. They recognized and rewarded excellence and they provided room for career growth, learning, and development.⁴ Davis et al⁵ define clinical ladders as a voluntary promotion, designed to recognize the increasing skills and responsibilities of personnel without requiring the employee to seek promotion to the supervisory level or to leave direct clinical practice. Finally, Ripka and Fouser⁶ state that a clinical ladder program offers the opportunity to reward extra employee effort and performance while improving individual job satisfaction, personal recognition, and patient care. While the preceding definitions are somewhat different, the overlying theme of all is employee growth, recognition, and retention.

There are several program names currently used with this type of program—clinical ladders and career ladders are the most prevalent. Other naming conventions include Professional Technologist Advancement Program (PTAP),⁷ Career Advancement Program (CAP),⁴ Multimodality Career Path,² and Clinical Practice Recognition Program. While there is no precise rationale for determining a naming convention, Ron Barak, RT(R), CRA, Regional Manager Radiology, Broward General Medical Center and Paul Dubiel, Director of Imaging, Seton Healthcare Network have indicated their naming decisions came as a result of



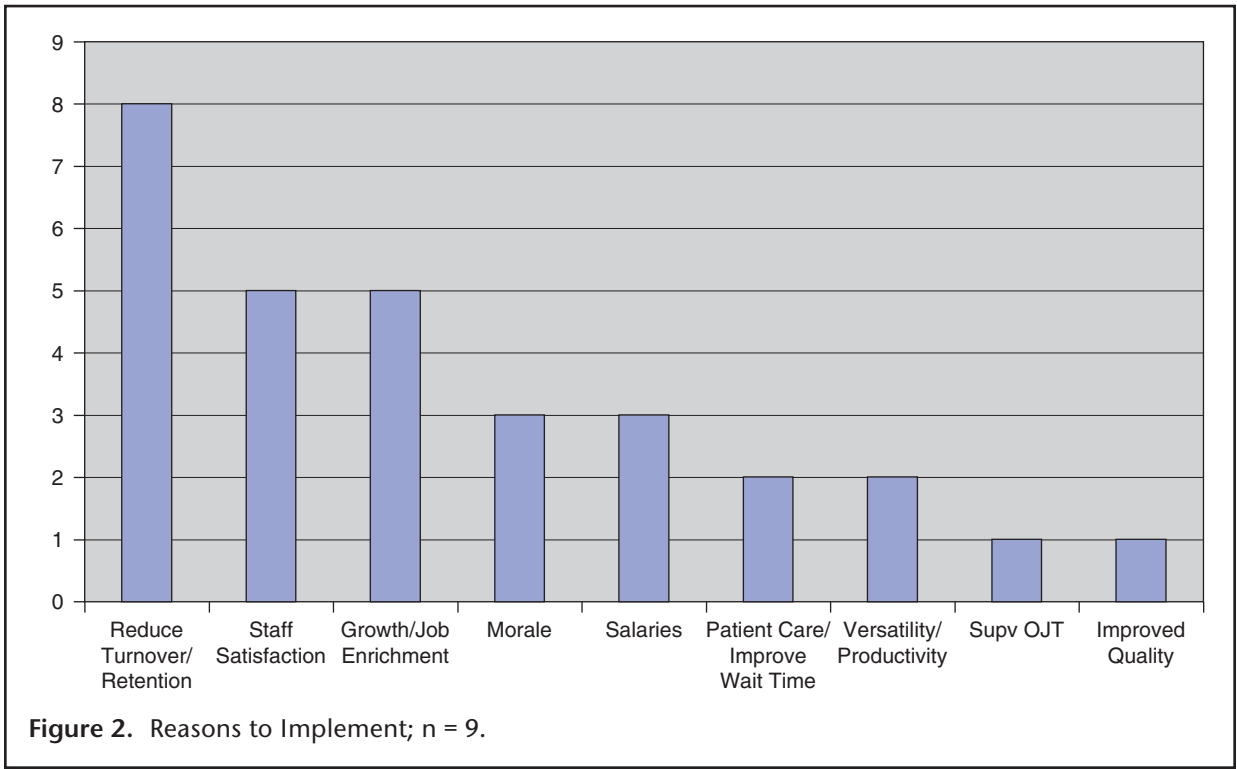
existing nursing career ladder programs at their respective facilities (personal communication, October 2006).

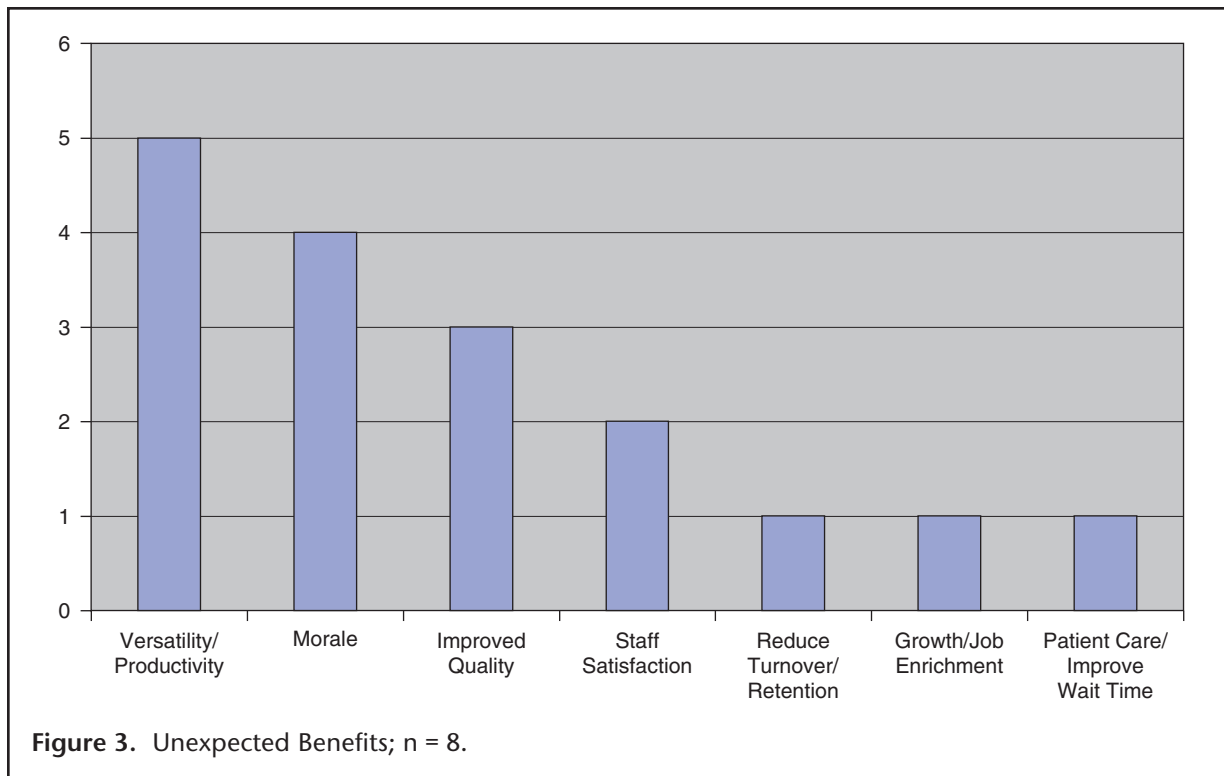
In this case study, 4 administrators were surveyed and an additional 5 career ladder programs were analyzed from available literature. Of the feedback received and research conducted, 9 implemented career ladders for diagnostic technologists, 6 for CT and special procedures, 5 for MRI and nuclear medicine, 4 for ultrasound, 3 for mammography, and 1 for PACS (see Figure 1). Additionally, 1 person stated

future plans to implement a program for CT, MRI, and ultrasound and another stated plans to implement a program for nuclear medicine and ultrasound.

Why Develop Clinical Ladders?

There are many reasons to implement career ladders; however, this research indicated reducing turnover/retention as the reason most cited (see Figure 2). Other reasons to





implement a program include staff satisfaction, growth/job enrichment, morale, salaries, patient care/improve wait time, versatility/productivity, and supervisor training. More interesting data was obtained when sources were questioned about the unexpected benefits of career ladder implementation (see Figure 3). Five sources indicated versatility/productivity and 4 sources indicated morale as unexpected benefits.

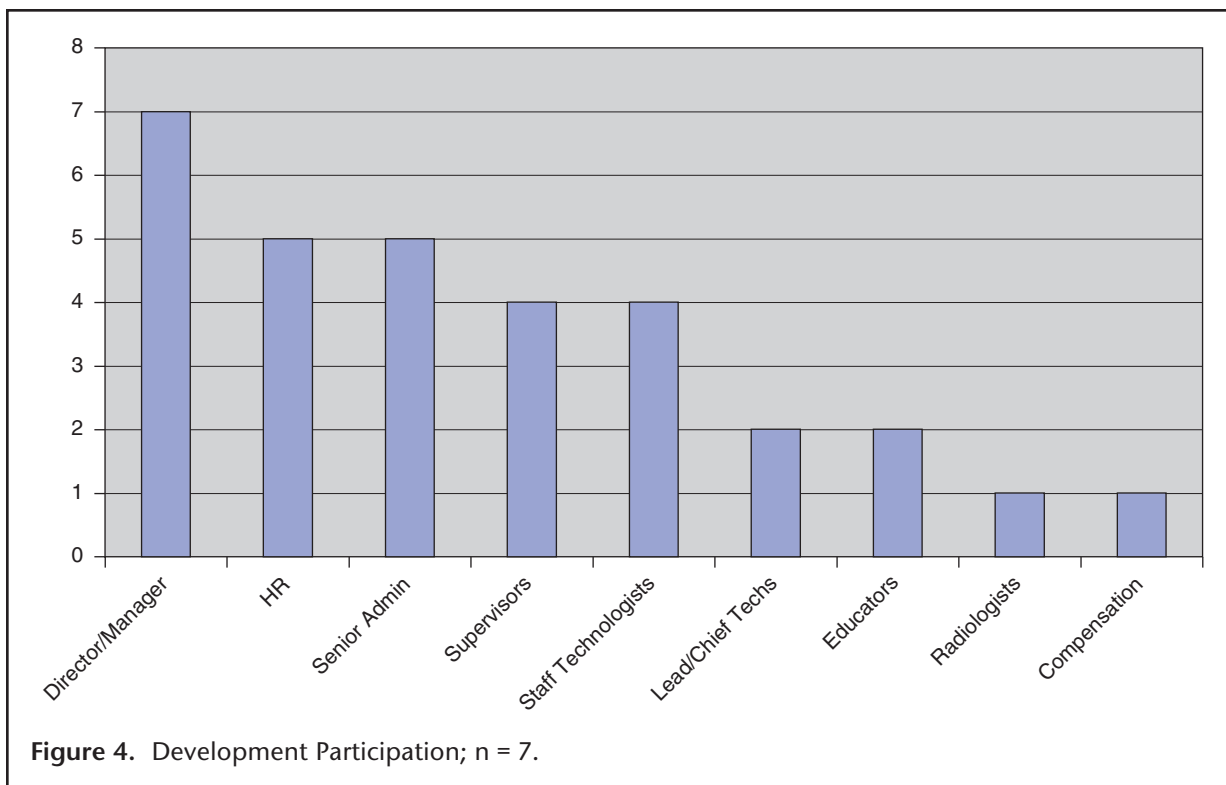
When asked about their reasons for implementation and if effectiveness was measured and if acceptable results were achieved, 2 of the 4 radiology administrators responded "yes" to both questions and 1 had a mixed response. Richard Ragovin, RT (R), Director Radiology, Robert Wood Johnson University Hospital indicated that he measured the effectiveness of his program relative to retention and morale and achieved acceptable results. While he did not specifically measure, he feels he has achieved increased versatility. Dubiel measured and achieved acceptable results in many areas after the implementation of clinical ladders in his department, including increased technologist satisfaction, reduced turnover,

increased patient throughput, and reduced patient wait time. Penny Olivi, MBA, RT(R), FAHRA, CRA, Senior Administrator, Department of Radiology, University of Maryland Medical Center indicated that while she did not formally measure job enrichment, the staff has expressed satisfaction with the level of participation, responsibility, and authority afforded by the ladder program. Further, Olivi has measured retention and has seen very little turnover over the last 4 years (personal communication, October/November 2006).

Program Development

Much of the information gathered relating to career ladder development is quite varied; however, one common trait is the formation of a team for program development. Research overwhelming revealed the use of a multi-disciplinary team approach to include many levels of radiology leadership: human resources/compensation, radiology educators, senior administrators, radiologists, and staff technologists

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(see Figure 4). Including staff technologists on the development team would not only help promote buy-in among peers, but would foster staff involvement and ownership. Educators can serve to implement and conduct staff education, as well as bridge communication and serve as a conduit for questions and concerns. One administrator interviewed suggested that regular staff meetings included progress reports, allowed for questions, and sought new ideas. Of the 5 sources listing senior administrators as team members, 2 clarified their roles as advisory and providing approval as necessary.

It is important to emphasize regular working team meetings and the realization that the program will not be built in a day. Pinette states the process was very time consuming and required intense discussion and debate.⁴ Davis said the greatest challenge in devising a clinical ladder program across multidisciplinary lines was to set criteria which would meet the needs of the diverse disciplines.⁵ In the early stages of program development, the team must identify reasons to

implement career ladders, formulate a purpose, and outline measurable goals.

During the development process, it is important to determine the minimum number of levels required to accomplish established goals. Findings among those interviewed for this study indicated 3 levels as most common, but others range from 2 to 7 (see Table 1). All but 2 people stated their first level as entry or new hire.

In conjunction with the discussions surrounding the number of levels, the team must decide on the education, experience, behavior objectives, and performance criteria for each level.⁸ For example, these requirements may include patient satisfaction indicators, performance evaluation, and quality assessment that meets or exceeds standards, documentation of expanded productivity, continuing education, direct involvement in CQI projects, added leadership responsibility, implementation of cost savings initiatives, etc. Career ladder requirements can also include advancements in clinical skills,

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1st Level	2nd Level	3rd Level	4th Level	5th Level	6th Level	7th Level
Tech I*	Tech II					
Rad 1*	Rad 2	Rad 3				
Tech*	Senior	Lead				
CL I	CL II	CL III				
Tech I*	Tech II	Tech III				
Level 1	Level 2	Level 3				
Level I*	Level II	Level III	Level IV			
Tech I*	Tech II	Tech III	Tech IV	Tech V		
Rad Tech I*	Rad Tech II	Rad Tech III	Rad Tech IV	Rad Tech V	Rad Tech VI	Rad Tech VII

*Entry Level or New Hire

such as CPR instruction, interventional procedures, and preceptor responsibilities. Regardless of the many options available, career ladder design should correspond to departmental needs and organizational goals.

Additionally, the level of difficulty to complete each requirement should correspond appropriately to the goals and objectives, as well as correlate to financial incentives. Pinette states that “[It] is a very formal process and meant to be so. It takes time, energy and commitment . . . work, motivation and dedication. It is not just handed out haphazardly or just because an employee has worked . . . for a lengthy time. It must be earned . . . It is attainable but not so easy that it is no longer a challenge. It is meant to add value to the employee as well as to the department.”⁴

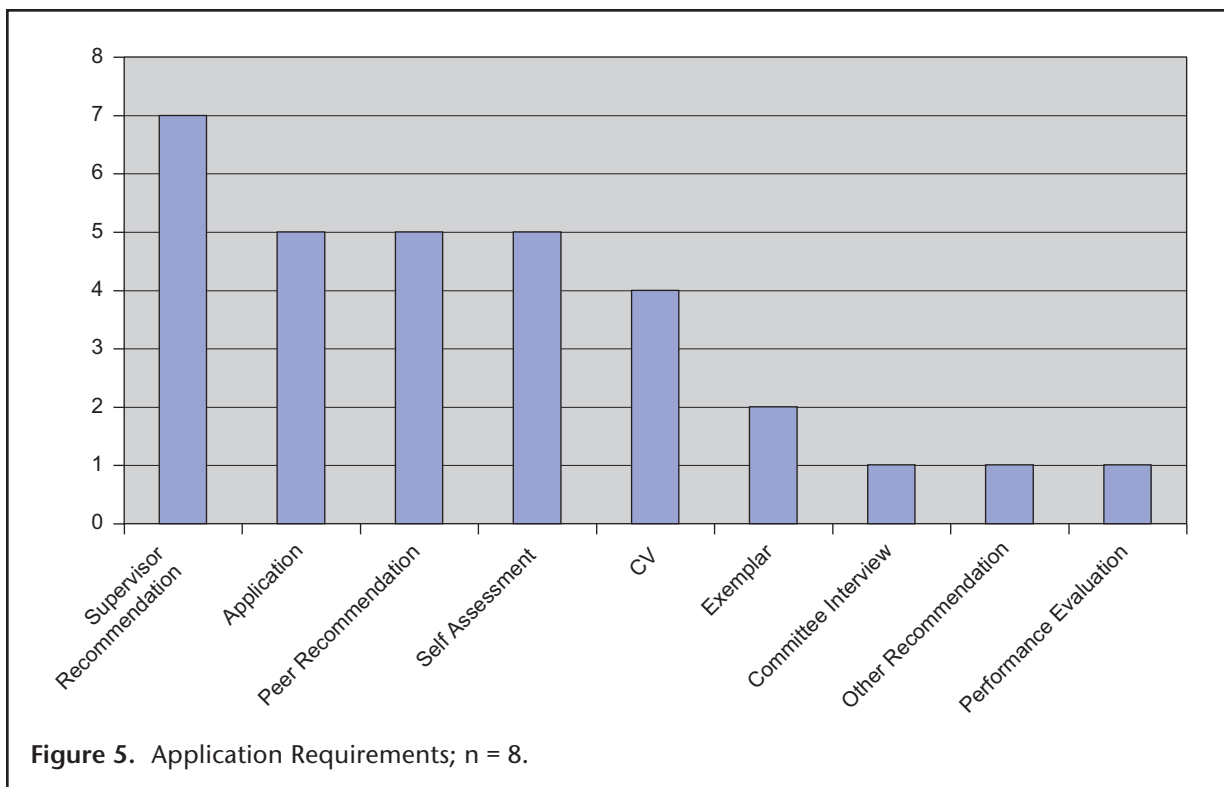
Qualification criteria, as well as a clearly defined application process, must be considered and developed by the team. The team must decide the minimum requirements for beginning and progressing through each subsequent level of the career ladder program. Interviews conducted showed submission of a supervisor recommendation, application, peer recommendation, and self-assessment most commonly used in established career ladder programs (see Figure 5). Collectively, recommendations (supervisor, peer, and other) were used by all respondents, which is a testament to their

significance. Recommendations should attest to the character and qualifications of an individual. Ideally, a variety of people would have input (such as peer, manager/supervisor, radiologist, transport/clerical staff) similar to the 360 evaluation concept. Inclusion of an application can ease the review process by quickly highlighting minimum qualifications and providing a checklist for the employee to ensure all components are attached.

The use of exemplars is a good way to test an employee’s critical thinking skills. An exemplar is a written example of behavior worthy of imitation. Pinette states a customer service/patient care exemplar is written by the employee and describes a specific situation in how they played an important role, left a positive impact, and really made a difference to one of the customers or patients. Further, Pinette explains the staff is also required to write a professional practice exemplar in which they describe in detail how they personally handled a difficult and/or challenging situation with equipment, procedure, physician, staff, or other hospital employee.⁴

It is also important to determine the maximum number of staff allowed at any one level. For example, research indicates great variation relative to this issue so it is clear that teams have designed this portion of their program according to very specific departmental needs, current staff qualifications, and/or

Qualification criteria, as well as a clearly defined application process, must be considered and developed by the team. The team must decide the minimum requirements for beginning and progressing through each subsequent level of the career ladder program.



budgetary limitations. Olivi stated that at her facility the majority of staff in the career ladder program are at the Rad 2 level with a smaller number of staff above and below, similar to a normal bell curve distribution. She went on to say that Rad 3 technologists are chosen for where and when they work. For example, if a Rad 3 technologist working nights wants to take a day position, their Rad 3 may not necessarily move with them. If there is a need for a Rad 2 on days, then the employee will need to decide whether to stay as a Rad 3 on nights or transfer to a Rad 2 on days. Dubiel stated that while his facility has discussed limitations, an unofficial cap on level III has occurred because there are a limited number of employees who are qualified or want to qualify (personal communications, October/November 2006).

There are currently a limited number of official salary structures associated with career ladders. The straight percent structure is designed to pay the same percent on base pay for each level of the career ladder. Research indicates straight

percent is the most common method used and ranges from 3% to 10% per level. The variable percent structure is designed to pay a different percent on base pay for one or more levels of the career ladder. Gillan states 5% for levels I to VI and 7.5% for level VII. A bonus structure pays a lump sum on a predetermined interval. This is most common when the employee must requalify for the career ladder level. Bonus amounts can be the same for each level or variable. Last, a certification/differential pay structure can be established whereby once an employee achieves the next level, a set amount is paid in addition to regular wages. The amount can be either a percent (eg, 3% of base wages) or flat amount (eg, \$2.00 per hour).

Certification/differential pay methodology also implies requalification. The advantage of straight percent pay is its simplicity. Variable percent is also simple and rewards those employees who challenge themselves to advance in the career ladder program by offering a higher percent farther up the ladder. The bonus and certification/differential pay methods

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are designed to hold the staff accountable to maintain their career ladder levels at a predetermined interval. Additionally, overall annual wage increase expense is less when utilizing bonus and certification/differential pay methods since these are not included in base hourly rate. If requalification is required when using straight and variable percent methods, it can be very difficult to decrease an employee's hourly rate if they are not successful. Once the pay structure, application timeline, and evaluation schedule have been established, program costs can be estimated.

The final step in developing a career ladder program is creating a procedure manual. This should include a letter of introduction, purpose, goals and guidelines, job descriptions, salary structure (if desired), an application, and any other documents appropriate to your specific program. Ideally, all documentation would be available electronically for easy access.

Program Implementation

The most important part of implementing a career ladder program is the communication of the program to the staff. As previously stated, including a staff technologist on the development team would promote buy-in and foster staff involvement and ownership. Roll out meetings facilitated by each of the development team members will not only expedite communication of the information, but will create excitement as it will send an early message of unity and depth in the department. Like any new program, not all staff will welcome career ladders. Some may see them as insulting, intimidating, or too difficult. Additional communication with these employees from a trusted peer or supervisor may go a long way to ease their anxiety. Gillen stated technologists were encouraged at all times to perceive the project as beneficial and to appreciate their role in the growth of the department.¹

Monitoring Effectiveness

Once career ladders are implemented and an adequate number of employees have had an opportunity to climb a rung or two, it is important to measure the effectiveness of your program. You might analyze your program by asking the following:

- Did you reach the goals outlined in the development phase?
- Are your reasons to continue career ladders the same as your original reasons to implement career ladders?
- What were some of the unexpected benefits of your program?
- What opportunities have surfaced as a result of staff satisfaction surveys relative to the program?
- What would you have done differently during the (1) development and (2) implementation of your career ladders?
- If you have not implemented career ladders in all areas of your department, are you ready to expand?
- Do the results of the effectiveness measures of your existing program justify expanding to other areas of your department?

- Have you evaluated your career ladder program for continual improvement opportunities?

Conclusion

"The clinical ladder is a channel for clinical advancement . . . that requires the general radiographer to meet qualifications in clinical practice, leadership, day-to-day operations, continuing education, patient and student radiographer education, quality improvement, and service excellence."⁷ Moreover, career ladders are a way to increase productivity and staff versatility, improve morale, clinical quality and staff satisfaction, reduce staff turnover, promote professional growth and job enrichment, and improve patient care. Time, careful planning, and a team approach should be utilized when creating career ladders, followed by communication and program effectiveness measurement.

Resources

The following radiology administrators and AHRA members contributed significantly to the content of this article. Additionally, they have agreed to share their knowledge with you.

Ron Barak, RT(R), CRA
Regional Manager Radiology
Broward General Medical Center
Resource and Career Ladder Documentation
Planning implementation of ed CT, MRI, diagnostic, ultrasound, mammography, special procedures, and nuclear medicine programs in Spring 2007.
To contact Ron, please e-mail rbarak@nbhd.org

Paul Dubiel
Director of Imaging
Seton Healthcare Network
Resource and Career Ladder Documentation
Implemented diagnostic program in June 2005, plans to implement CT, MRI, and ultrasound programs at a date to be determined.
To contact Paul, please e-mail pdubiel@seton.org

Penny Olivi, MBA, RT(R), FAHRA, CRA
Senior Administrator, Department of Radiology
University of Maryland Medical Center
Resource and Career Ladder Documentation
Implemented CT, MRI, diagnostic, and special procedures programs in 2002 and nuclear medicine and PET CT in 2004.
To contact Penny, please e-mail polivi@umm.edu

Richard Ragovin, RT (R)
Director of Radiology & Radiation Oncology
Robert Wood Johnson University Hospital
Resource and Career Ladder Documentation
Implemented CT, MRI, diagnostic, ultrasound, mammography, special procedures, nuclear medicine, and clerical programs in 1992 and PACS in 1997.

To contact Rich, please e-mail rich.ragovin@rwjuh.edu or call 732-937-8613

I would like to extend a very special thank you to Ron, Paul, Penny, and Rich. Without input of their knowledge and experience, this article would not have been possible.

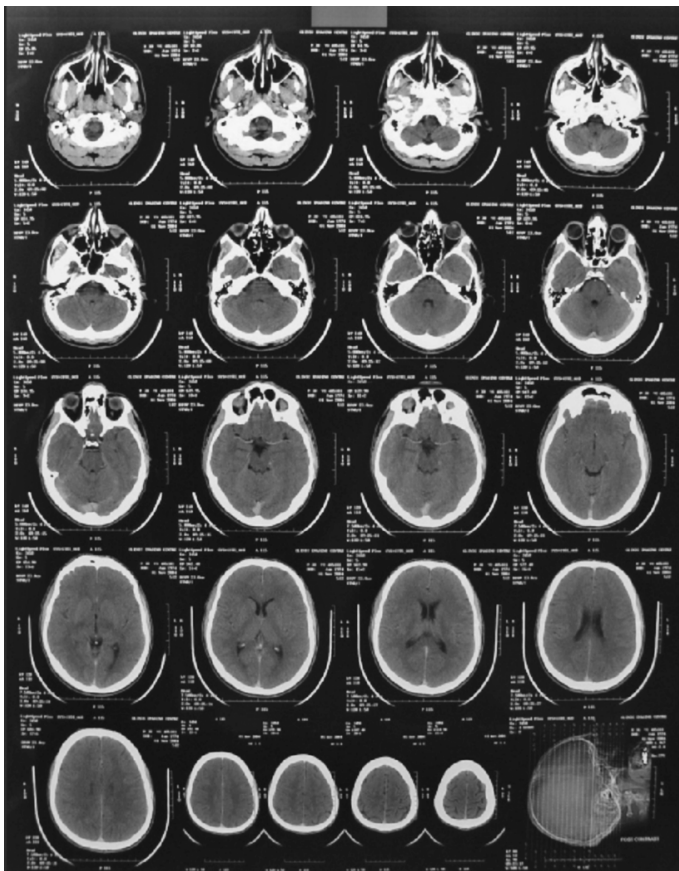
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clinical ladder program. *Administrative Radiology*. 1991 Jan: 10(1).

- ⁶Ripka G and Fouser C. Implementing a clinical ladder program. *Caring*. 1992 Sep: 11(9).
- ⁷Casanas JA and Coello HM. On the road to clinical advancement. *RT Image*. 2005 Feb: 18(7).
- ⁸Esposito-Herr MB and Olivi P. Managing clinical ladders in your department. Presented at: AHRA 34th Annual Meeting and Exposition; August 1, 2006; Las Vegas, NV. Audio-tape available at www.ahraonline.org.

Michelle M. Wall is the director of radiology at Saint Peter's University Hospital in New Brunswick, NJ. She is currently on the Board of Directors for AHRA, has a master of science in health services administration degree from Regis University in Denver, CO, a bachelor of business administration degree from Detroit College of Business in Warren, MI and is a Certified Radiology Administrator. She may be contacted at mwall@saintpetersuh.com.



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Carefully read the following multiple choice questions. Mark your answers on the answer sheet found on page 52 and mail or fax the answer sheet to:

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Questions

Instructions: Choose the answer that is most correct.

1. **According to Peterson, who proposed the first model for clinical advancement?**
 - a. Ripka in 1980
 - b. Zimmer in 1972
 - c. Fouser in 1960
 - d. None of the above

2. **Which of the following defines the term “career ladder?”**
 - a. A voluntary promotion, designed to recognize the increasing skills and responsibilities of personnel without requiring the employee to leave direct clinical practice.
 - b. A program that offers the opportunity to reward extra employee effort and performance while improving individual job satisfaction, personal recognition, and patient care.
 - c. A system of employee salary progression that provides for advancement through a set of graded steps or levels.
 - d. All of the above

3. **Another name used for a career ladder:**
 - a. Career Advancement Program
 - b. Professional Technologist Advancement Program
 - c. Multimodality Career Path
 - d. All of the above

4. **What is the most cited reason for implementing a career ladder?**
 - a. Staff satisfaction
 - b. Growth/job enrichment
 - c. Reducing turnover/retention
 - d. Versatility/productivity

5. **After implementing a career ladder in his department, what acceptable results did Dubiel achieve?**
 - a. Increased technologist satisfaction
 - b. Reduced turnover
 - c. Increased patient throughput
 - d. All of the above

6. **What is the most common trait reported regarding the development of a career ladder?**
 - a. Formation of a team for program development
 - b. It is based on a request from staff technologists
 - c. The financial implications are substantial
 - d. None of the above

7. **One way to help promote buy-in among peers and to foster involvement and ownership is to:**
- Use a career ladder plan from another institution
 - Include staff technologists on the development team
 - Have senior administration develop the career ladder
 - All of the above
8. **According to Davis, what was the greatest challenge in devising a career ladder program across multidisciplinary lines?**
- Setting criteria which would meet the needs of the diverse disciplines
 - Getting permission from senior administration
 - Including all disciplines represented in the hospital
 - None of the above
9. **When is it appropriate for the development team to identify reasons to implement career ladders, formulate a purpose, and outline measurable goals?**
- At the completion of the project
 - Prior to requesting permission from the administration
 - In the early stages of program development
 - None of the above
10. **What is the most common number of levels included in a career ladder?**
- 2
 - 3
 - 5
 - 7
11. **The development team must decide on the education, experience, behavioral objectives, and performance criteria for:**
- Level one only
 - Level seven only
 - Each level
 - None of the above
12. **The level of difficulty to complete each requirement should correspond and/or correlate to:**
- Goals and objectives
 - Financial incentives
 - Length of the program
 - Both a and b
13. **The minimum requirements most commonly used for beginning and progressing through a career ladder program include:**
- A supervisor recommendation
 - A peer recommendation
 - A self-assessment
 - All of the above
14. **What is a good way to test an employee's critical thinking skills?**
- Standard test
 - Report for supervisor
 - An exemplar
 - None of the above
15. **What issues might be used to determine the maximum number of staff allowed at any one level?**
- Budgetary limitations
 - Current staff qualifications
 - Specific departmental needs
 - All of the above
16. **A straight percent structure is designed to pay the same percent on base pay for each level of the career ladder.**
- True
 - False
17. **A variable percent structure is designed to pay a different percent on base pay for one or more levels of the career ladder.**
- True
 - False
18. **Once the pay structure, application timeline, and evaluation schedule have been established:**
- The development team is no longer needed
 - The program costs can be estimated
 - The applicants can be screened
 - The staff technologists can be involved in the planning process.
19. **What is the final step in developing a career ladder program?**
- Signing up the participants
 - Disbanding the development team
 - Determining the application timeline
 - Creating a procedure manual
20. **According to this author, what is the most important part of implementing a career ladder program?**
- Finding appropriate funding
 - Convincing senior administration that it is appropriate
 - Communicating the program to the staff
 - None of the above



ANSWER SHEET

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