The Strengthening Hospital Nursing Program: Organizations to Improve Patient Care

BY THOMAS G. RUNDALL, DAVID B. STARKWEATHER AND BARBARA NORRISH

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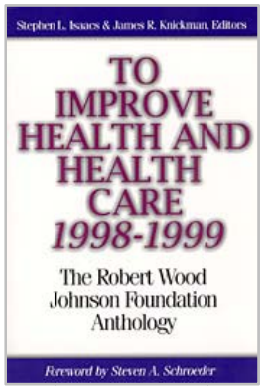

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Editor's Introduction

The Strengthening Hospital Nursing program described in this chapter was planned in the mid-1980s and has unfolded in some unexpected ways over the past ten years. The impetus for the program during its planning phase was clear and simple: to help hospitals address the problems caused by shortages of nurses in the 1980s. However, the cofunders of the program–the Robert Wood Johnson Foundation and the Pew Charitable Trusts–quickly widened the scope of this expensive and highly visible program. It became, over time, a focal point for increasing the role of nursing and transforming the basic approach to patient care within hospitals.

In the 1990s, as the program was unfolding, it faced two substantial environmental obstacles: first, the nursing shortage that had motivated the program evaporated, leading to serious questions about the purpose of the program; and second, the spread of managed care and ever-increasing financial pressures facing hospitals became more dominant forces in shaping approaches to patient care than the approaches offered by this program.

It is difficult to assess the success or failure of this program definitively because it addressed ambitious, difficult-to-measure goals and because so much change was taking place in the nation's hospitals. There have been constant concerns within the Foundation, however, that the goals of the projects selected were too broad and that the theory that nursing could lead fundamental changes in overall hospital structure is not viable.

Partly because of these concerns, the Robert Wood Johnson Foundation and the Pew Charitable Trusts asked Thomas Rundall, David Starkweather and Barbara Norrish from the University of California, Berkeley's School of Public Health, to take an outside look at the program. In this chapter, they summarize the results of their evaluation and present an in-depth report on three of the twenty Strengthening Hospital Nursing sites. The authors conclude that even though the program was overtaken by changes in the health care field and may not have accomplished what it was supposed to, it still led to many positive results in the sites where it was undertaken.

In the 1980s, there were widespread reports of a nursing shortage in the United States. Hospitals had difficulty recruiting and retaining nurses. The increasing use of complex biomedical technology, the demand for hospitalization by a growing elderly population and changing patterns of medical care resulting in shorter but more acute hospital stays contributed to the need for more hospital nurses–and for more intense and skilled nursing care. Despite a nationwide supply of more than two million registered nurses, or RNs, and a hospital RN-to-patient ratio that had doubled over the previous twenty years, hospitals across the country reported critical vacancies for budgeted nursing positions. Many hospitals were forced to delay admissions, or even close beds, because of an inadequate number of nurses on staff. Many factors contributed to the nursing shortage of the eighties, but two of the most frequently cited were the high level of job dissatisfaction caused by nurses' seeming lack of control over their work and poor working relationships with physicians and nonclinical staff members. To respond to these concerns, the Secretary of Health and Human Services appointed a special Commission on Nursing to study the problem and make recommendations. In 1988, the Commission published sixteen specific recommendations and eighty-one strategies to relieve the nursing shortage in the United States.

That same year, the Robert Wood Johnson Foundation and the Pew Charitable Trusts announced a jointly funded national initiative to provide better patient care through innovative, hospital-wide restructuring. From the outset, the foundations recognized the inherent connection between quality hospital patient care and strong hospital nursing services, and entitled their national program Strengthening Hospital Nursing: A Program to Improve Patient Care, or SHN. The SHN Program rested on two fundamental principles. First, SHN projects were to restructure hospital working environments to use nursing resources optimally, improve care in a cost-effective manner, and provide satisfying service designs for patients as well as nurses and other staff. Second, participating hospitals would be given great flexibility in the means they chose to identify organizational and operational problems having an impact on their current nursing services and in the measures they would take to remedy these problems and improve patient care.

Early in the development of the SHN Program, the SHN national program director, Barbara A. Donaho, and associate director, Mary Kay Kohles, wrote, "The Strengthening Hospital Nursing Program seeks to bring about a fundamental change in the U.S. hospital–from a discipline-driven, departmentalized institution to a patient-driven, unified one. It seeks an awakening by the hospital to the understanding that the patient is why it exists. It seeks a metamorphosis–a shedding of the old, tired image of the

nursing profession and constructing a better-fitting image in keeping with what the profession actually contributes to patient care."

Clearly, this was an ambitious program, and it was designed and overseen with recommendations from an advisory board of nationally recognized leaders in nursing and medical care. The supporting foundations provided not only monetary resources but also institutional legitimacy to the effort. The challenges facing the grantee hospitals were to a significant extent understood by the program planners and the national governing staff, and these challenges were anticipated in many features of the program. At each site, a considerable investment was made in the education, training and empowerment of a team of people who could facilitate change. In short, there were good reasons to believe that the SHN Program would be successful.

The flexible nature of the program meant, however, that success could be assessed only in the local context of each hospital's circumstances. Each hospital was planning a unique project tailored to its particular problems. Moreover, given the five-year term of the program, it was likely that planned projects would have to be modified over time, and that unplanned strategies and projects would emerge.

The total financial commitment of the Robert Wood Johnson Foundation and the Pew Charitable Trusts to the program was $26.8 million: $4 million for one-year planning grants, $20 million for the five-year implementation grants, and $2.8 million for technical assistance, program administration and monitoring. Many of the hospitals ultimately selected as grantees augmented their foundation grant with their own funds.

In October 1990, the two foundations announced that twenty projects–twelve hospitals and eight consortiums of hospitals–had been selected to receive five-year SHN implementation grants of up to $1 million each. The hospitals and the hospital consortiums selected to receive implementation grants are identified in Exhibit 6.1. The group of grantee hospitals was diverse, including rural and urban, large and small, academic and community hospitals.

The proposals of the grantee hospitals shared some common themes, including the following:

- The development of institution-wide initiatives for change and communications networks that would last beyond the grant's planning and implementation phases.
- The use of planning and implementation processes that relied on collaboration and consensus building horizontally as well as vertically within the hospital.

- The use of organizational and management consultants to facilitate the hospital planning team's ability to envision new models of nursing and patient care.
- A focus on providers' relationships with patients rather than with one another.
- Cross-training of professional staff.
- Unbundling hotel services from patient care services.
- Self-governance for individual nursing units.
- New models of nursing care.

PREPARING SHN GRANTEES TO CREATE CHANGE

To help the grantees acquire the tools to change their hospitals effectively, the national office of the SHN Program sponsored a number of educational workshops. Teams from the grantee hospitals, consisting of the chief executive officer, the nurse executive, members of the board of trustees, a medical staff representative and the SHN project director, were required to attend an initial educational conference held in September 1989 in Orlando, Fla., and a follow-up two-day workshop. These educational sessions were an integral part of the year-long planning process. A consultant to the National Program Office, Russell L. Ackoff, emeritus professor of systems science at the Wharton School of the University of Pennsylvania, led the project teams through the principles and applications of systems thinking. Each planning phase grantee then prepared a detailed five-year plan for restructuring the workplace to strengthen hospital nursing and improve patient care.

EVALUATING SHN

The authors conducted an evaluation of the SHN program between 1994 and 1997.[1] The specific projects for change at each of the nine study sites are presented in Exhibit 6.2. To enable us to see the larger picture, we classified each project by whether it was aimed primarily at a change in a patient care process, in a service, in administration, or in human resources.

Changes in Patient Care Process

All nine SHN study sites implemented process changes such as redesigning patient care pathways and creating new pathways for cardiovascular, cancer, maternity, pediatric, intensive care and emergency patients, among others. The changes in the patient care process were often accompanied by an increased use of nonprofessional patient care assistants, cross-training of professional staff people and the use of a case manager to coordinate care across the continuum of services. Another major theme of the changes in patient care process at SHN hospital sites was the emphasis on creating and supporting a team approach to care. In several instances, new centers were created to provide an organizational mechanism

for supporting the team approach to patient care and the integration of the care of patients across traditional disciplinary boundaries.

Typically, changes in the patient care process were the most difficult ones for hospitals to adopt, because they were the ones most likely to be resisted by physicians and nurses, who often viewed them as threatening to their current job responsibilities and their autonomy. Moreover, changes in patient care processes often required changes in the activities of many ancillary and support personnel, which significantly complicated the process.

Service Changes

Six of nine SHN study sites supplemented their changes in the patient care process with the introduction of new services. These varied greatly, with each site creating new services uniquely tailored to its patients' needs and the existing services. Some new services added to the array of direct patient care services available at the hospital, such as special attention to the victims of domestic violence and sexual assault, hospice care, outpatient chemical dependency treatment, cardiac rehabilitation and a program to give patients more control over their hospital care. Other new services were designed to expand the continuum of care to include prehospital and posthospital services, such as an informational video for patients about to be admitted to the hospital, referral programs linking the hospital to the patients' home-town nursing services and a faith ministry. Two sites established new patient education centers to help patients and their families learn more about their health problems and participate more fully in the planning and carrying out of their treatment regimens.

Administrative Changes

The changes in the SHN hospitals' patient care processes and services were often accompanied by changes in the administrative structures and processes of the hospital. Eight of the nine study sites adopted such changes. In several sites, the organizational structure of the hospital was changed through the implementation of shared governance, the creation of new committees, the use of matrix organizational structures and the introduction of new administrative roles to support the clinical staff. The introduction of shared governance in hospitals was one of the most favored changes, because it decentralized decision-making, giving staff members more control over their work. However, even this change was resisted by some nurses and others who preferred simply to "do their job" and not be burdened with the responsibility of participating in making work process, staffing and personnel policy decisions.

One common administrative change was to strengthen the hospital's information systems. This was accomplished in a number of ways. More information and feedback from patients was acquired through the use of patient questionnaires and focus groups. In one hospital, the site of much patient-related data collection and storage was moved to the patient's bedside. Additionally, two hospitals designed and adopted new computer-based information systems to support the care providers. The task of making information systems more useful for clinical and managerial work was complex and difficult, affecting virtually every department in the hospital. However, staff at several study sites commented that the inadequacy of their information systems was a barrier to making administrative and other changes, indicating that significant value could be added to the patient care process with an improved information system.

Human Resources Changes

Seven of the nine study sites created human resources development programs to provide administrative and clinical staff with the conceptual tools and the practical skills necessary to bring about change. These programs developed staff members' knowledge of the process of organizational change, introduced them to new approaches to patient care, taught effective communications skills, emphasized the importance of teamwork and reinforced the values and beliefs supportive of a patient-centered focus for the hospital. Frequently, these human resources activities were packaged as leadership development programs. Other human resource changes included the development of new training programs for clinical nurses, staff performance recognition programs and training in continuous quality improvement techniques.

THREE CASES

Perhaps the best way to gain an understanding of the changes adopted by the SHN hospitals, and of the impact those changes had on nursing and patient care, is to examine three distinctly different cases: Beth Israel Hospital in Boston, D.C. General Hospital in Washington, D.C., and the Rural Connection, a consortium of Idaho Hospitals.

Beth Israel Hospital

Beth Israel Hospital, in the center of Boston's medical metropolis, serves as one of the primary teaching hospitals for the Harvard School of Medicine. It is nationally recognized as one of the nation's premier health care institutions. The 408-bed hospital provides a full range of acute care services. In addition to its reputation as a leader in the field of medicine, Beth Israel Hospital is recognized both nationally and internationally for its professional nursing practice model (primary nursing) and the quality of its nursing care. Under the leadership of Joyce Clifford, the hospital's vice president for nursing and nurse-in-chief,

the nursing division at Beth Israel successfully developed and adopted primary nursing in 1974. This model of professional practice has been emulated widely in hospitals throughout the United States. Elements of this model of nursing practice at Beth Israel include an individualized patient relationship, twenty-four hour accountability for nursing care, admission-to-discharge accountability for a patient by one nurse who cares for that patient when present, case-based management of care through the use of nursing care plans as well as direct communication between caregivers and associate nurses who provide care in the absence of the primary nurse consistent with the plan of care developed by the primary nurse.

Underlying the primary nursing model was the value the organization placed on the clinical practice of nursing. Dr. Mitchell Rabkin, the president and chief executive officer, or CEO, of the Beth Israel Health System, said his philosophy "is that the hospital is fundamentally a nursing institution," and added, "Doctors don't like to hear me say that. Basically, we are nurturing the patients for a variety of perturbations that are carried out by doctors." The Strengthening Hospital Nursing Program enabled Beth Israel to change its patient care model from primary nursing to a new model referred to as integrated clinical practice.

WHY CHANGE? The awareness of the need for change at Beth Israel was stimulated by factors both internal and external. Two of the major internal forces were the increasing severity of patients' illnesses and the decreasing length of stay, which resulted in greater demands on the nurses. Jane Ruzansky, the director of nursing for surgery, commented on the importance of these factors: "With managed care, patients' conditions have become very complex–patients were staying for shorter periods of time, and a lot [of the care] was happening outside the hospital. We knew that new graduates were having a harder time managing the complexity of the patients. We heard from clinical instructors that they were overwhelmed with the difficulty of patients and figuring out assignments."

External factors also pressured Beth Israel to change. At the time of the planning grant–1989–it was clear that managed care was on the horizon. Increasing competition for managed care contracts required the hospital to reduce its costs. According to Joyce Clifford, "None of us had any notion of how difficult that environment was going to get." In 1994, the nursing division budget was reduced by 127 positions, mainly from inpatient nursing. During this period, the hospital experienced an increased volume and a decreased length of stay.

The theme of loss was frequently identified as an experience affecting the nursing staff in a variety of ways. The closure of a nursing unit resulted in "losing friends that we have worked with for ten years" as well as the loss of a manager. Some nurses experienced monetary losses with the elimination of ten-hour shifts. Also, as one nurse reported, it was "really painful for nurses to watch patients going home much sooner than they thought they should be going home. It was sad for nurses to be sending patients out when the nurses would like them to stay [so they could] take care of them."

THE SHN PROGRAM AT BETH ISRAEL. The SHN program at Beth Israel was a five-year project designed to redefine the role of the professional nurse in caring for patients across the continuum of care. The program title, Integrated Clinical Practice, stressed the complex interdisciplinary approach believed to be necessary to enhance patient care. Four major goals were articulated to guide SHN grant activities.

- To span the system of care and the spectrum of illness so that continuity in patient and family care is improved and experienced, advanced practitioners of nursing are utilized effectively in achieving a consistent quality and standard of care. The development of care teams was one of the principal mechanisms by which nursing was able to span the continuum of care.
- To restructure the organizational framework of hospital nursing practice based on professional and career development concepts for novice through expert nursing practice. The Clinical Nurse Entry Program was the major initiative adopted to achieve this goal. This program was a two-year first work experience for new nurses. New nursing graduates were provided with a preceptor and a guided orientation to the hospital work environment and the job expectations for a clinical nurse.
- To refine and strengthen interdisciplinary collaboration, especially that of physician and nurse, through integrated systems for the planning and the management of patient care. The creation of care teams, previously described, was the principal initiative to accomplish this goal.
- To develop institutionally focused, patient-centered support systems for the delivery of care. Two new patient-centered positions were created to provide support to professional staff. The support assistant performed tasks previously done by housekeeping, dietary and transportation staff. The practice coordinator provided support to the nurse manager by coordinating the administrative activities of a nursing unit.

CARE TEAMS. Care teams were designed to improve the continuity of care for different services and at various sites, and to promote an interdisciplinary approach to patient care. Membership on the Care Teams was fluid, flexible, and inclusive; any care provider who wanted to participate was welcome. Care Teams were given latitude to redesign patient care so that they could achieve the goals of the grant: continuity, career development, interdisciplinary collaboration and spanning the spectrum of illness and the system of care.

The Hematology/Oncology Care Team illustrates the effects of care teams on nursing and patient care. This team involved everyone in the department, including physicians, nurses and support staff members. The major work of this group was "breaking down the barriers between [inpatient and outpatient] settings and really looking at ourselves as an integrated practice," one of the team members remarked. Group activities were designed to "make a patient's experience seamless, so that from a patient's perspective, receiving care in any setting, or from anybody in the department feels like it's the same focus, the same themes, the same materials. This included improving communications, and, from the patient's focus, making it feel very coordinated."

One strategy to improve communications and the coordination of care was integrating the role of nurses so that they could practice in both the ambulatory and the inpatient oncology settings. The nurses involved had a caseload of patients they cared for in both settings. By the fourth year of the grant (1993–94), four nurses were practicing in the role. As this model evolved, practice groups were formed that linked a small group of inpatient nurses with a physician's ambulatory practice. A team member commented on the impact of this change on patients: "We've put one integrated practice nurse in each practice group. For any patient seen in that ambulatory practice, there is a nurse who also takes care of patients on the inpatient unit who has some knowledge of them. From a patient's point of view, that's been very reassuring–to see a familiar face, to know someone who has known them in an ambulatory setting."

Other strategies were used to improve communications between the inpatient and ambulatory staff about the care of patients. Patients newly diagnosed on the inpatient unit were referred to the ambulatory unit by the primary nurse, and an ambulatory nurse who would care for the patient after discharge was identified before discharge. Information about the patient's hospital stay was shared with the ambulatory nurse, and, if possible, the nurse met the patient before discharge. Another method to improve communications was the implementation of the same patient assessment tool in the radiation oncology unit, the inpatient oncology unit and the ambulatory hematology-oncology unit. Further, patient education materials were made consistent among the three units.

The major source of resistance to Care Teams came from the nursing staff. According to Ellen Powers, the nurse manager for hematology/oncology, staff members were able to understand the external pressures for creating change. "I think people understood that piece," she said. "These are experienced clinicians who are very good at adaptation and who have very appropriate values around patients and

practice. So I think they could logically understand the grant and the changes in health care, and the reasons for this. However, the change was threatening to staff at a personal level. It was just that they didn't like how it felt to them to have to change. They had been in a certain pattern for a long time, and nobody had ever examined it or asked them to examine it, and now they were being asked to look at things very deeply." Resistance was eventually overcome by providing staff time to adjust to the changes. Also, the grant provided an opportunity to showcase the achievements of the Care Team at meetings and in the newsletter, thus providing positive feedback to the members.

SUPPORT ROLES. During the first year of the grant, 1990–91, a work analysis team was formed to determine how best to support the nursing staff in caring for patients. The goal was to relieve the nurses of chores that they didn't need to be doing so they could spend more time taking care of patients. Out of the planning the work analysis team did, two new roles were created: the support assistant and the practice coordinator.

Support Assistant. The people in these new positions were assigned to a patient care unit, becoming part of the patient care staff, and were trained to clean patient rooms, deliver and collect meal trays, and transport patients to and from tests. "I think the patients supported this," the SHN project director, Laura Duprat, noted. "When things were going tough and we could look at those [patient] comment cards and realize that it really impacted patients in a great way, we couldn't not move the program forward. It was very important to have that feedback from patients."

By 1996, however, the role of support assistant had been adopted only by three demonstration nursing units. A major obstacle to the hospital-wide adoption of the program was the cost. Although the cost of the program was lower than the centrally based support services on weekends and holidays, it was slightly more expensive during the week. Full implementation was contingent on moving the program forward in a way that didn't cause budget increases.

Practice Coordinator. The practice coordinator was responsible for "making sure the unit has what it needs to run smoothly and if it doesn't, to work on those systems to make things happen," Laura Duprat commented. "We found that nurse managers were spending so much time worrying about [operational matters], they couldn't do their jobs, and we decided they really needed to be focusing on nursing." In addition to overseeing all nonclinical functions, the practice coordinator planned and organized the work of unit-based support staff, developed systems to enhance unit operations, devised policies and

procedures to ensure efficient processing of work, and prepared and monitored supply and expense budgets.

CLINICAL NURSE ENTRY PROGRAM. The hospital traditionally hired new graduates immediately upon graduation and, after a brief orientation, expected them to function as full members of the nursing staff with no additional formal career development. The typical orientation acquainted graduate nurses with hospital policies and procedures and prepared them to fulfill the job description for registered nurses on a particular patient care unit. What was lacking was systematic, ongoing, formalized attention to the professional development of the nurse beyond the orientation period.

The Clinical Nurse Entry Program was designed to provide new graduates with clinical skills and to ensure that they adopted professional values. New graduates were hired for a two-year residency. During this period, they received a standardized residency experience that emphasized not only clinical competence but also systematic career planning and orientation for the role of the nurse. As part of this orientation, the new graduate had a clinical nurse mentor–an experienced nurse who understood the importance of value-based practice. Nurse residents functioned as members of the nursing staff and maintained a caseload of primary patients. However, the planned process of acquainting the new graduate with the nursing profession was the distinguishing characteristic of the entry program.

District of Columbia General Hospital

The District of Columbia General Hospital is a 482-bed acute care hospital in Washington, D.C. Established in 1806, the hospital provides health services for the residents of the community regardless of their ability to pay and serves as a safety net for vulnerable populations within the District of Columbia. Frequently it is the provider of last-resort care. The hospital also provides medical education through affiliation with the medical schools of Georgetown University and Howard University.

The patient population served by D.C. General consists predominantly of patients who, for reasons relating to poverty, social circumstances, health (including mental health) status, employment, race and culture, make up the community's most vulnerable populations. These patients tend to be high-risk, complex patients who experience multisystem disease. In addition to providing specialty inpatient care, the hospital is a major provider of primary and other ambulatory care.

D.C. General also provides emergency and trauma services, and at the time of the planning grant–1988–89–the Emergency Department was the busiest in the Washington, D.C., metropolitan area with an average of 200,000 visits a year. Some 88 percent of the inpatient population was admitted through the Emergency Department.

As the only acute care public hospital located in the nation's capital, D.C. General was responsible both to the District of Columbia government and to the United States Congress, and this dual responsibility resulted in a highly politicized governing structure subject to the changing nature of political control. The hospital staff was highly unionized. Staff physicians were unionized, and so were nurses and other professional, technical and support staff people.

WHY CHANGE? The recent history of D.C. General reveals an organization fighting for survival and buffeted by the winds of political change, including a changing governing structure. In the late 1960s, the hospital became the responsibility of the District government, losing its federal status. In 1977, a semi-independent commission, named by the mayor, was created to manage the hospital. This commission had the authority to make physical, personnel and policy changes. Fiscal crises have been the focus of more recent concerns, and further changes in the governing structure have been proposed to address the financial situation. Plagued by chronic budget deficits, the District of Columbia government had repeatedly called for budget cuts and staff reductions to cope with an almost yearly operating loss at the hospital. At the time of the planning grant in 1989, the organization was experiencing an increasing emphasis on cost containment, quality of care outcomes and productivity.

In addition to extreme turbulence from the outside, a great deal of disturbance occurred on the inside. Four different chief executive officers served during the grant funding period, and this turnover contributed to a lack of consistent organizational mission and vision. The hospital historically suffered from staff shortages, inadequate nonclinical support systems and underutilization of automated labor-saving mechanisms. At the time of the planning grant, the hospital had had to reduce the number of beds it could make available. Staff morale was low, and there was a high turnover of registered nurses.

In short, D.C. General displayed few of the characteristics one would expect to see in a hospital undertaking successful organizational change. In the midst of this turbulence, however, the appointment of Nellie Robinson as the associate administrator for nursing in 1987 served as a catalyst for change. Nellie Robinson was identified as a charismatic leader who was able to articulate her vision of a patient-

centered hospital, and to mobilize people to bring about change. The combination of visionary leadership and highly unsettled conditions created a sense of a fighting spirit in the organization, and provided the motivation to rise above the challenges.

THE SHN GRANT AT DISTRICT OF COLUMBIA GENERAL HOSPITAL. The Strengthening Hospital Nursing grant activities at D.C. General focused on the goal of creating a system emphasizing the patient as the key stakeholder in the health care system. Achieving this goal meant restructuring of services at the unit level. The four major SHN projects undertaken by the hospital were collaborative care project teams, patient focus groups, guest relations and the hospital staff recognition program. The project most fundamentally affecting patient care was that of the collaborative care project teams.

These teams provided a structured, administratively supported forum for interdisciplinary discussion, collaboration and problem solving. Representatives from many departments were invited to provide their expertise in designing a more efficient, patient-friendly environment. Group members attended an educational session conducted by consultants from the Center for Applied Research, and were thus provided with a common language and tools to accomplish the work of the group. Teams were authorized to take responsibility for certain problems and to arrive at solutions.

Five project teams were established during the third year of the grant, in 1992, but only four of them survived to the fourth year of the grant. Each project team functioned in a unique way, and most were able to accomplish some significant changes in care delivery. For example, the pediatric team addressed and solved more than twenty problems affecting patient care, such as decreasing the waiting times in the pharmacy from more than sixty minutes on average to fifteen minutes, decreasing triage time by initiating triage coding, and decreasing waiting time to see a physician in the outpatient clinic from sixty minutes to twenty. The surgery unit project team decreased the length of stay and the cost of caring for two groups of patients.

Unfortunately, the project teams were not sustained, for several reasons. Some physicians resisted the creation of the teams from the outset. The associate administrator for nursing noted, "Physicians were not used to spending time in meetings; they were used to giving orders, not working things out as a team." The hospital's medical director also noted that involving physicians was difficult because they regarded the grant as being specifically for nursing.

Other factors causing the demise of the project teams were related to the general turmoil affecting the hospital. In 1993, during the third year of the grant, the project staff was administratively transferred from the Nursing Division to the Office of the Executive Director. The associate administrator for nursing believed that by having those responsible for the grant report to the hospital's chief executive officer the program "would get proper attention and we would be able to achieve 100 percent cooperation." She wanted to get away from the "stigma of this being a 'nursing grant.'" When the grant was administratively transferred to the CEO, however, he did not have time to provide the necessary direction for it because of the demands external issues imposed on his time. According to one of the consultants, the CEO did not view the grant as strategically important. Nellie Robinson was able to provide leadership and support to the project team's activities, but in 1993 she left D.C. General, and the leadership of the project was assumed by Rachel Smith, who had been actively involved in the unit-level activities of the project teams. Smith continued to provide enthusiastic leadership for those teams, but she left in 1994, and there was no one to continue to champion the project teams. The SHN project director also left the organization in 1994 and was not replaced.

During this same period, the hospital CEO and other members of senior management had to focus not on the grant but on tremendous external changes that threatened the survival of D.C. General. The movement to Medicaid managed care resulted in a decline in patient volume at D.C. General, and, with more hospitals in Washington willing to care for Medicaid patients, many in the community intensified the debate about the need for a public hospital. In the fall of 1995, an interagency task force was appointed by Washington's mayor to create a public benefit corporation to govern the hospital. At the same time, members of Congress were calling for the closing of the hospital. In response to the resulting instability, the hospital began experiencing tremendous personnel turnover. In May of 1995, the city government called for a reduction in force of 200 employees and 60 physicians. Fear of the unknown caused many staff people to resign. Because of a hiring freeze, new nurses were not recruited to fill vacancies created by the turnover. Many of the unit aide positions were lost in the reduction, and nonnursing tasks once again fell to the staff of registered nurses. In 1995, registered nurses took a 12 percent salary reduction, and the management staff experienced a 4 percent across-the-board salary reduction—this after a four-to-five-year period without any salary increase. Essentially all of the major participants in the grant activities left D.C. General before the grant ended. According to the hospital's executive director, the hospital employed one-third fewer employees in 1996 than it had when the grant began.

Activities related to the Strengthening Hospital Nursing grant effectively ceased in the latter part of 1994, during the fifth year of the grant. The organization was not able to complete its SHN implementation plan, and never fully adopted the SHN grant projects. The only bright note is that despite the cessation of grant-related projects, many staff members are convinced that life is different at D.C. General as a result of the grant. According to the director of social work, "[Something] very powerful has happened to those involved in the program and their relations with other disciplines.... They are able to reach out and speak to each other.... This has permeated to line staff, who are buying in as a philosophy and a way of life."

The Rural Connection

The Rural Connection was a consortium project that included an urban medical center, a rehabilitation hospital, four rural hospitals and a university. The initiating organization was St. Luke's Regional Medical Center, a 252-bed hospital in Boise, Idaho. Other hospitals that made up the consortium included Idaho Elks Rehabilitation Hospital (Boise), Holy Rosary Medical Center (Ontario, Ore.), McCall Memorial Hospital (McCall, Idaho), Walter Knox Memorial Hospital (Emmett, Idaho) and Wood River Medical Center (Sun Valley, Idaho). The four rural hospitals are separated by many miles of mountain ranges and desert. Travel among them is complicated by harsh and unpredictable winter weather conditions.

WHY CHANGE? The initial interest in using the Strengthening Hospital Nursing grant to support change came from the relatively new leadership of St. Luke's Hospital–its president, Edwin Dahlberg, and its vice president for patient care services, Sharon Lee. St. Luke's Regional Medical Center was founded in 1902 by an Episcopal bishop who wished to provide a facility to care for the sick in his parish. Since its founding, St. Luke's has been a regional leader in health care. In 1968, the first open-heart surgery performed in Idaho was done at St. Luke's. In 1993, 1994 and 1995, St. Luke's was named one of the country's top hundred hospitals by HCIA, Inc., and William M. Mercer. Clearly, the staff of St. Luke's took great pride in being recognized as an industry leader, and the new executives at the hospital wanted to maintain the status of St. Luke's.

This desire was acknowledged by Edwin Dahlberg, who attributed interest in the grant to "the fact that I was relatively new at that time, and Sharon was new." He added, "The folks who were new were willing to take it on. The new people were expecting some change." Sharon Lee believed that the grant had great potential, and her enthusiasm was infectious. Joe Caroselli, the administrator of Idaho Elks Rehabilitation Hospital, said of Lee, "You would get around her and she would start talking about the

grant like it was a religion. She knew it was a lot of work, and she was going to do some and you were going to do some, too. She was able to engage others and get them involved."

THE SHN PROJECT AT THE RURAL CONNECTION. The SHN projects involving the Rural Connection included those set up within each participating organization and a consortium-wide project. The goal of the consortium-wide project was to develop an interagency system of rural health care delivery–specifically, to develop regional standards of care for patients experiencing a heart attack and requiring thrombolytic therapy.

During the first two years of the grant, the Rural Connection focus was on projects at each of the consortium hospitals. At the end of 1991, however, the Rural Connection received a wake-up call from the SHN National Office. At that time, the Rural Connection project director was frustrated by what she believed to be a lack of progress on grant initiatives and a lack of organizational focus on the grant. Rather than focusing on the progress that had been made, she submitted a report to the national SHN project office that emphasized what had not been accomplished. The result was a surprise visit from Mary Kay Kohles, the deputy director of the SHN National Program, during which the threat of losing the grant was identified as a possibility unless further progress was achieved.

After that visit, the work of the Rural Connection took on a much broader focus. The members of the consortium began to look at improving the health care of the larger community, rather than concentrating on issues specific to an individual hospital. As Connie Perry, the project's coordinator, explained, "We knew that there were patients who go back and forth between our hospitals and we knew we were not doing a very good job of managing them. And we knew we were caring for them in the most expensive way–repeating every test, collecting the same information. The right hand did not know what the left hand was doing. The patient would come back, no one knew they were back, no one knows what had happened. So we said, 'How can we build a continuum of care?'"

THE CONSORTIUM THERAPY PROJECT. The first regionwide project of the rural consortium was the development of regional standards of care for patients experiencing a heart attack and requiring therapy. The end result was a protocol of care for these patients that described standards of treatment in the rural hospitals. These included standards for identifying patients with chest pain who were candidates for thrombolytic therapy, standards for the timing of the administration of thrombolytic therapy, and standards for appropriate transfers and community-based follow-up care.

The success of this project was in large measure due to the ability of the project leader to bring together a group of skilled and knowledgeable people who would not normally have worked together. For example, Joe Caroselli at Idaho Elks Hospital described his involvement:"I think there was a lot of effort to try and get different people into different roles. The idea of getting disinterested people involved was visionary. I quickly became aware that these people representing these various hospitals really were concerned about this cardiac patient population. They began to see they could make a difference in the lives of these people and the basic purpose of the group was that we were going to add muscle to the community." Additionally, this group brought together people involved in different aspects of the care of cardiac patients who had not previously collaborated in planning for patient care, including physicians, emergency medical services personnel, hospital nurses and patient care staff at the rehabilitation hospital.

The Rural Connection myocardial infarction/thrombolytic therapy regional design group was so focused on improving the care of these patients that its work easily crossed over organizational boundaries, even to the point where consortium hospitals worked collaboratively with competing hospitals. "About three-fourths of the way through the project, it was clear that St. Luke's and its network was definitely in control of the cardiac patient," Caroselli said. "But there was a competing hospital across town. Through this vision of this particular group, who had all the protocols established, they said, 'If anyone in this community has an infarct and did end up at [the competing hospital],' this group wanted to make sure the patient was attended to. So that barrier broke down." The competing hospital was approached, and it agreed to participate in the protocols. Involving the competing hospital "put the focus on what we're really here to do," Caroselli said.

In 1996, a year after the grant funding terminated, the work of the Rural Connection was continuing. Moreover, the model was in the process of being applied to three other patient groups: obstetrics, stroke and breast cancer.

CONCLUSION

The nursing shortage of the 1980s appears to have given way to a more complicated picture in the mid-1990s. During the early nineties, new market forces, including the increasing use by payers of per diem and capitated hospital reimbursement and competition among hospitals for contracts with managed care plans, changed the demand for hospital nursing. As managed care techniques were adopted by health plans and providers, hospitals were required to cope with declining patient days, fewer admissions and lower payments. Many diagnostic tests and treatments were routinely provided on an outpatient basis

and in outpatient settings separate from the hospital. The use of the hospital for the observation of patients as part of the diagnostic regimen was greatly reduced. Similarly, hospitals were little used for bed rest of patients, as more out-of-hospital exercise-oriented regimens for treatment and rehabilitation of both acute and chronic diseases were adopted. Although the patients who were admitted to hospitals were typically sicker and more complex cases than was true through most of the 1980s, pressure from payers of all sorts to reduce hospital costs caused hospitals to attempt to redesign hospital work to reduce lengths of stay while maintaining quality of care. Increasingly, hospitals sought to cut costs by reducing the number of full-time equivalent employees, cutting nursing hours per patient, and lowering overall wages by employing fewer high-cost registered nurses.

There continues to be significant pressure on nursing staffs to use more nonprofessional assistants for mundane tasks, while maintaining a highly trained professional workforce to care for an increasingly acutely ill inpatient population. If anything, in the mid-1990s the forces acting on hospitals to transform the patient care process have strengthened.

The changes implemented by the Strengthening Hospital Nursing sites ran deep and wide. Using patient-centered care as a conceptual touchstone, the clinical and administrative staff in these hospitals adopted many innovations, and in some cases true organizational transformation was realized. Core patient care processes were redesigned, affecting the practice patterns and the working relationships among many different clinical care providers. In many cases, patient care practice was for the first time standardized. Serious efforts to create an integrated continuum of care were observed, with further restructuring of long-established turf boundaries and work roles. Cross-training of staff and the use of assistants to provide nonprofessional aspects of patient care further challenged the personal beliefs and institutional norms regarding best practices and improving patient care. It is important to note, however, that the changes in patient care processes were adopted at the same time that new services and products were being introduced and new administrative and human resources structures and processes were being put in place to support the changes in patient care.

Among the SHN study hospitals, the importance of the resources made available by the SHN planning and implementation grants was frequently cited as the key to building the capacity to change. "People say, 'It wasn't so much the grant money,' but it was the money," one project director said. "This is what allowed us to learn the process, stretch the rules, learn how to develop others, undertake training around

the patient care process. Without the grant, we would not have been as rich, nor as sustainable, nor as spirited."

The importance of larger environmental forces on hospital decision-making cannot be ignored, however. The penetration of managed care and competition among hospitals for contracts to provide care to patients covered by managed care plans were important stimuli for hospitals to reduce costs, improve care and increase patient satisfaction. On the negative side, as demonstrated in the case of District of Columbia General Hospital, dramatic budget cuts, large numbers of personnel layoffs and rapid turnover in senior management positions can be devastating to a hospital's efforts to improve patient care. The Strengthening Hospital Nursing Program was not designed to solve such problems, and it did not.

Our eight other SHN study sites did make lasting improvements in patient care, however, and in most cases created new models of nursing practice and new relationships among nurses and other providers of care. Perhaps the most fundamental changes observed in SHN hospitals was a reaffirmation of the importance of the patient and a reorganization of hospital activities around the patients' needs. These changes will surely strengthen the role of those care providers having the most contact with patients–hospital nurses.

Notes

[1] Case study methodology was used to study the SHN Program. The five-year SHN implementation grants were funded in 1990. The research team conducting the case studies of the SHN Projects was assembled and began work in 1994, and continued to conduct site visits to selected grantee institutions and collect data via other means through July 1997. Because of limited resources, only nine of the original twenty SHN grantees could be studied. Hence, in 1994 we selected nine of the sites for maximum variability in key program, organizational and environmental characteristics. The nine selected sites were:

1. Abbott Northwestern Hospital, Minneapolis, Minn.
2. Beth Israel Hospital, Boston, Mass.
3. D.C. General Hospital, Washington, D.C.
4. Health Bond (a consortium of hospitals), South Central, Minn.
5. Providence Medical Center, Portland, Ore.
6. Rural Connection (a consortium of hospitals), Boise, Idaho
7. University Hospitals of Cleveland, Cleveland, Ohio
8. University Hospital, Salt Lake City, Utah
9. Vanderbilt University Medical Center, Nashville, Tenn.

EXHIBITS
6.1 Types of Changes Made in Strengthening Hospital Nursing Study Sites
6.2 Strengthening Hospital Nursing Program Implementation Grants