IF IT AIN'T BROKE, FIX IT!:
BETH ISRAEL HOSPITAL

Beth Israel had a strong and pervasive organization culture that supported innovation and change. The culture was created by Beth Israel's top management, notably Joyce Clifford, RN, Ph.D. and Mitchell Rabkin, M.D. Drs. Clifford and Rabkin had unusually long tenures in their leadership roles at Beth Israel, and their progressive and effective leadership styles contributed much to the culture that was established in the hospital.

The culture emphasized respect for each employee and the expectation that each can and will grow and contribute. Nurses were recognized as centrally important to patient care and were held in high esteem. The culture fostered constant incremental change through an attitude of "if it ain't broke fix it anyway." The culture encouraged people to cut across and through the traditional hierarchy to accomplish new things. Though Beth Israel was large and complex there was little bureaucratization. The culture purposely supported informal communication and coordination within its traditional hierarchy. For this reason Beth Israel saw little reason to formally change its structure in order to institutionalize the patient-centered changes it introduced.

Because of Beth Israel's culture of progressive change, it "absorbed" the Strengthening Hospital Nursing grant with little fuss and no new structures. None were considered necessary at Beth Israel, just as such structural changes were considered essential in our other cases. By the same token it became difficult for the hospital or anyone else to distinguish the changes wrought by the grant from changes that would have happened anyway. In a hospital with a well deserved reputation for excellence in patient care and devoted to thoughtful change by increment, restructuring to improve patient care was bound to happen. Under these circumstances the nature and process of change at Beth Israel Hospital were different and subtle. The case reveals how "the devil was in the details."
The Organization

Located in the center of the Boston’s medical metropolis, Beth Israel Hospital served as one of the primary teaching hospitals for the Harvard School of Medicine. Nationally recognized as one of the nation’s premier health care institutions, BI was licensed for 408 beds in 1995. The hospital provides a full range of acute care services, including multiple medical and surgical specialties, psychiatry, obstetrics and gynecology, emergency care, and a Level I trauma service.

In addition to its reputation as a leader in the field of medicine, Beth Israel Hospital (BI) 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, R.N., Ph.D., Vice President for Nursing and Nurse-in-Chief, the nursing division at BI successfully developed and implemented primary nursing in 1974. This model of professional practice has been adopted widely in hospitals throughout the United States. Elements of this model of nursing practice at BI include: continuity in nurse-patient relationships over time; 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. Organizational leaders believed that nursing makes an important contribution to the outcomes of patient care. Mitchell Rabkin, M.D., President and CEO of Beth Israel Health System, stated that his philosophy “is that the hospital is fundamentally a nursing institution. 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.”

At Beth Israel, the Strengthening Hospital Nursing Program enabled BI to change their patient care model from primary nursing to a new model referred to as integrated clinical practice (ICP).

Why Change?

The awareness of the need for change at BI was stimulated by factors both internal and external to the organization. Two of the major internal forces motivating the change were the increasing patient acuity and the decreasing length of stay, which resulted in increasing demands on the registered nurse. Jane Ruzanski, R.N., the Director of Surgical and Psychiatric Nursing, commented on the importance of these factors, “Patients have become very complex with managed care--patients were staying a shorter period 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 BI 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 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 RN FTEs. Most of the FTE reduction came from inpatient nursing. During this period, the hospital experienced an increased volume and 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 have we 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, one nurse reported that it was really painful for nurses to watch patients going home much sooner than they thought they should be going home.

**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, emphasized integration and highlighted the complex, interdisciplinary approach believed necessary to enhance patient care. Four major goals were articulated to guide SHN grant activities.

1. 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. The care team assumed responsibility for patient outcomes and provided support and resources to the primary nurse to achieve the desired outcomes of care. Care teams increased efficiency by reducing the randomness of care team development. Rather than assembling a team for each patient at the time of admission, care providers developed interdisciplinary teams that routinely worked together to care for patients. Continuity of care was accomplished by decreasing the number of different care providers. Another SHN initiative designed to accomplish the goal of spanning the continuum of care was the development and implementation of the Patient and Family Learning Center. Through the Center, nursing staff provided self-care training to patients and families, making the patient’s return to home easier.

2. Restructure the organizational framework of hospital nursing practice based upon professional and career development concepts for novice through expert nursing practice. The Clinical Nurse Entry Program was the major initiative implemented to achieve this goal. The Clinical Nurse Entry Program was a two-year, planned, first work experience for new graduate
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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.

3. Refine and strengthen interdisciplinary collaboration, especially that of physician and nurse, through integrated systems for the planning and management of patient care. The implementation of Care Teams, previously described, was the principal initiative to accomplish this goal.

4. Develop institutionally focused, patient centered support systems for the delivery of care. Two new patient-centered roles were implemented 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.

Clearly the success of the BI Strengthening Hospital Nursing Program depended on the successful implementation of the Learning Center, the Clinical Nurse Entry Program, Care Teams, and Support Roles. The SHN projects at BI are summarized by the type of change below.

Care Teams

The transition from the primary nursing model of patient care to the integrated clinical practice model was most evident in the adoption of a team approach to patient care. Care teams were designed to improve the continuity of care across services and service sites, and to promote an interdisciplinary approach to patient care. Membership on the Care Teams was fluid, flexible and very inclusive; any one care provider who wanted to participate and further the work of the group was welcome. Care Teams were given much latitude to redesign patient care processes to achieve the goals of the grant: continuity, career development, interdisciplinary collaboration, and spanning the spectrum of illness and system of care.

The following discussions of the implementation of the Hematology/Oncology Care Team and the HIV Care Team will illustrate the effects of Care Teams on nursing and patient care.

Hematology/Oncology Care Team

This Care Team included everyone in the department, including physicians, nurses, and support staff. 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.” 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 communication and coordination of care was the implementation of an integrated nurse practice role that enabled nurses to practice in both the ambulatory and the inpatient oncology settings. These nurses carried a caseload of patients they cared for in both settings. By the fourth year of the grant (1993-1994), four nurses were practicing in the role. As this practice 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 also used to improve communication 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 prior to discharge. Information about the patient’s hospital stay was shared with the ambulatory nurse and if possible, the nurse met the patient prior to discharge. Another method to improve communication 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 evaluated and made consistent among the three units.

The major source of resistance to Care Teams came from the nursing staff. According to Ellen Powers, Nurse Manager for Hematology/Oncology, staff were able to understand the external pressures driving the change. “I think people understood that piece. 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 ICP updates and in the newsletter, thus providing positive feedback to the members as changes were accomplished.

**HIV Care Team**

Formed in May, 1991 during the first year of the grant, this was an interdisciplinary work team that included physicians, nurses, and social workers. The goal of the team was to improve the care of patients with HIV. Early meetings of this team revealed turf issues and issues of patient ownership, which the team addressed through the use of case presentations. According to Laura Duprat, “A psychiatrist on the team [suggested that] what we ought to do is have a case presentation of a patient at the beginning of each meeting. As a technique, it worked like magic.
The first time someone came and presented, everyone in the room suddenly realized they had been involved with the patient. All of a sudden they could see each other’s roles emerging, and there was this understanding that this is a team effort and everyone has a role to play."

Another technique used by the team to emphasize the patient was the use of patient focus groups. During the second year of the grant, in January, 1992, members of the HIV work team completed a focus group with male HIV patients and another focus group with providers of care for HIV patients. During the third year of the grant, a focus group was held with women with HIV disease. The focus groups provided valuable information that guided team activities. As Laura Duprat described: “Between the tactic of a patient presentation each month and the patients’ stories from the focus group it all came together, and it was very obvious what this group needed to do and where the interventions were, and it was one of the easiest groups to facilitate because we had all the information we needed in a matter of months.”

A number of changes were implemented. A brochure was developed describing the array of services offered by the hospital for HIV patients. To meet better the needs of female HIV patients, a monthly women's HIV clinic was offered within the hospital-based primary care practice, and the social service department worked with a local college to have students provide free child care during the clinic session. Care coordination was enhanced through strengthening communication systems. Care Team members from nursing and social service collaborated to develop a discharge planning summary form that was made available on-line in the clinical computing system. The existing Outpatient Medical Record system was used to develop an on-line HIV clinical information program.

The Learning Center

The overall focus of the Learning Center was to teach patients how to take care of themselves after they return to their home. The Learning Center offered three types of patient education services. First, educational services were provided to help patients and families develop self-care skills to use in the home. Second, a Health Resource Center was established. The Center included a library of medical and health journals and books for use by patients and families. Third, an outreach program, Education for Life-long Well Being, was created that provided educational programs in the community.

Support Roles

During the first year of the grant, 1990-91, a work analysis team was formed. One of the goals of this group was to determine “how do you best support the nursing staff in caring for patients.” The goal was to “relieve the nurses of ‘stuff’ that they didn’t need to be doing so they could spend their time doing more important things like taking care of patients.” Out of this planning, two new roles were created: the support assistant and the practice coordinator.
Support Assistant

These support staff 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.

The feedback from patients about the Support Assistants was very positive. According to Mal Weiner, Vice President for Clinical Support Services, “A big difference is the relationship that they build [with patients]. We have done multiple studies of patient satisfaction and it is not uncommon for me to see references to ‘my support assistant’.” One staff member indicated that “When a patient goes to a floor where the role is not in place [they ask] why don't I have my support assistant on this floor because I had my support assistant on that floor.” The SHN Project Director, Laura Duprat, also noted the positive patient feedback. “I think the patients supported this. 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, the Support Assistant role had not been “rolled out” beyond three demonstration nursing units. A major obstacle to hospital-wide implementation 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 budget neutral manner.

Practice Coordinator

The Practice Coordinator provided support to the nurse manager by coordinating the administrative activities of a nursing unit. In addition to overseeing all non-clinical 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 Entry Nurse Residency Program

The strong commitment of Joyce Clifford and BI Hospital to the professional practice of nursing was the primary stimulus for the Clinical Nurse Entry Program (Clinical Entry Program). As Laura Duprat indicated, “Joyce [Clifford] works for the profession of nursing in addition to Beth Israel Hospital. She encouraged nursing leaders at the hospital to consider how the changing nature of hospital nursing was affecting new graduates” (Wandel, 1995, p. 1).

Nursing leaders at BI recognized that increasing patient acuity, decreasing length of stay, increasing use of technology, and increasing complexity of the registered nurse role in the acute care hospital made the transition from new graduate to practicing nurse more challenging. New
graduates “need skills to plan for complicated discharges, communicate with a variety of health providers, and delegate tasks to support staff” (Beth Israel, 1990).”

Beth Israel traditionally hired new graduates immediately upon graduation and, after a brief orientation, expected them to function as a full member of the nursing staff with no additional formal career development. The typical orientation acquainted the graduate nurse with hospital policies and procedures, and prepared them to fulfill the job description for a registered nurse 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” (Wandel, 1995, p. 1).

The Clinical Entry Program was designed to provide new graduates with clinical skills and to insure that they internalized professional values. New graduates were hired for a two-year residency. During this period, the new graduate received a standardized residency experience that emphasized not only clinical competence but also systematic career planning and socialization into the professional role of the nurse. Key to the socialization of the new graduate was an ongoing relationship with a clinical nurse sponsor, an experienced nurse who understood the importance of value-based practice. Learning activities were collaboratively planned by the sponsor and nurse resident to assist the resident in:

- demonstrating the centrality of caring in professional nurse/patient/family relationships;
- demonstrating competence in providing quality, cost-effective nursing care;
- demonstrating leadership skills in all aspects of professional practice;
- formulating a plan for continued development and overall career goals;
- appreciating the larger context of the health care delivery system.

Examples of learning experiences included “writing clinical narratives, shadowing clinical staff through certain specialized experiences, presenting patients at rounds, reviewing research articles or other literature, attending committee meetings, and meeting with resources from a variety of disciplines within the institution.” (Wandel, 1995, p. 1). Nurse residents functioned as members of the nursing staff and maintained a caseload of primary patients. However, the planned process of socializing the new graduate into the nursing profession was the distinguishing characteristic of the Clinical Entry Program.

Discussion

The SHN grant at BI was implemented in an organization with a long history and well-developed skills of motivating staff to implement changes to improve patient care. The expertise in managing change was evident in the ways in which the grant, almost from the outset, became indistinguishable from routine operations. The organization never relied on a separate grant governance structure to oversee project activities. Change, although stimulated by the leaders of
the organization, was allowed and encouraged to progress in a bottom-up process. Project staff were available to the nursing unit staff, but staff were given the flexibility to take from the grant goals and strategies that made sense and make it work for them. Once a project was identified, a person within the organization was selected to facilitate or coordinate project activities. These individuals were enthusiastic about the project, committed to the vision, and had the skills (including group, leadership, clinical and political skills) to work the project through the organization. For the most part, they were already a respected member of the BI staff.

A focus on managing the process of change has a long history at Beth Israel. The leadership is attuned to the impact of change on individuals in the organization, and managers respect the emotional and psychological impact of change. Dr. Rabkin described that he “look[s] at management in part as an intellectual occupation. …And so when we talk, we don’t just say, ‘we have got to do this; we have got to do that. We also talk about being a manager, and what being a manager means, and what we learn from various actions that are taken or how we anticipate people will react or respond to something.” Giving staff the time to process change is one major approach to managing change at BI. Dr. Rabkin believes, “You have to work through [change] emotionally….You cannot simply take bad news and have it handed down to the next layer of managers and expect them to promulgate it without them having the opportunity to go through the same intellectual and emotional processes you did to accept that change. They will not do it in a convincing way, and it will create disorder and disruption to whomever they manage or supervise.”

One strategy to support staff in working through change emotionally was providing staff, such as the psychiatric liaison nurse, who focused on the processes of change. Another strategy was to structure change activities in ways that included staff in planning. Most projects were associated with a number of planning and review groups, task forces, or committees. These groups provided multiple opportunities to involve staff in reviewing and contributing to projects prior to implementation. Additionally, these forums provided opportunities for staff to come together, share ideas, and get to know each other better. The result was a longer planning period that provided the opportunity to identify and deal with resistance. Additionally, potential problems that might be encountered during implementation were identified and addressed.

The grant activities were strategically important to Beth Israel as part of the organization’s commitment to excellent patient care. The pervasive belief within the organization that the quality of the nursing staff directly influences the quality of patient care assured organizational support for grant activities. Thus, grant activities were very much an evolution of an existing organizational strategy for promoting collaborative patient care. The strategic importance of grant activities was evidenced by the large amount of in-kind monetary support invested by the organization during the life of the grant.

The SHN program at BI also included an extensive evaluation of the impact of the grant activities. The outcomes of Care Teams was evaluated through a variety of evaluation
techniques. A descriptive evaluation of the Clinical Entry Nurse Residency Program compared the professional development of nurses in the residency program with that of nurses hired in 1992 who did not go through the residency. A study of nurses’ job satisfaction and voluntary turnover between 1993 and 1995 was conducted to provide an overall outcome measure of the SHN grant activities. In addition to these more extensive evaluation activities, other data were monitored to evaluate the impact of grant activities, including patient satisfaction data, volume statistics, and cost information.