

# With cost pressures up, will nurses be targeted again?

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**D**uring the 1980s, hospitals successfully transformed the model of nursing care from teams to primary nursing in which one registered nurse assumed primary responsibility for designing and modifying the patient's plan of care during hospitalization.<sup>1</sup> In hospitals with the primary nursing model in place, AIDS patients had superior outcomes—this, in an era before protease inhibitors were available.<sup>2</sup> Significantly, hospitals with primary nursing did not need to spend any more money than other hospitals to get better results.

The model of primary nursing, an approach that ensures patients enjoy continuity of care, was most fully developed at Beth Israel Hospital in Boston, with similar models adopted throughout the United States and Europe.

In the late 1990s, hospital managers were alarmed at the prospect of increased capitation for patient services and the resulting drop in reimbursements. The Balanced Budget Act of 1997 imposed further cuts on reimbursement for hospital services. Faced with impending fiscal crises, many hospitals and hospital systems looked to management and accounting consultants for ways to survive.<sup>3</sup> Their prescriptions were remarkably similar: by reducing labor costs through restructuring employee work, hospitals would increase “throughput” and achieve cost savings through efficient redesign of

employee work.<sup>4</sup> Given the size of the nursing budget in most hospitals, most of the labor reforms were targeted at nursing departments.

### **Beware the consultant**

In the 1990s, hospital consultants determined that primary nursing was inefficient; many tasks performed by nurses, they said, could be performed at lower costs by ancillary personnel. They recommended that nurses serve as supervisors, or heads of “care teams” that would deliver complex care, allowing “care partners” to perform such activities as taking vital signs, changing catheters, and dressing wounds. This team approach morphed nurses into supervisors of housekeepers and patient transporters.

A survey of registered nurses working in hospitals in the late 1990s found that many did not have enough time to prepare patients for discharge, teach patients and families, and perform necessary skin and mouth care to ensure comfort and prevent complications.<sup>5</sup> The same survey found that nurses were spending an extensive amount of time performing non-nursing duties such as housekeeping, patient transport, and food tray delivery. Many of the plans devised by consultants actually increased costs.<sup>4</sup>

In the meantime, registered nurses left hospitals for employment elsewhere in healthcare or outside the industry. As of 2002, it was estimated that nearly 17% of the 2.9 million registered nurses in the United States were employed outside of nursing,

contributing to the nation's predicted shortage of nurses.<sup>6</sup> Along with a rise in patient acuity, the shortage of experienced RNs has led to a crisis in hospital care in which errors have increased and patients with complications are not successfully managed.<sup>7</sup> The safety net provided by the successful, cost-neutral model of primary nursing was replaced with a well-intentioned but expensive and evidence-empty idea from management consultants.

### **Boom times**

Amidst a challenging hospital climate in which physicians were asked to increase patient caseload with fewer human and material resources, the community oncology market flourished. Medical oncologists in private practice could now answer to themselves instead of hospital administrators. They were free to create their own teams of nurses, pharmacists, and other support staff; establish their own formularies, chemotherapy protocols, and supportive care regimens; and design their patient workflow. Indeed, few physician specialties enjoyed so much autonomy in optimizing care for their patients. Oncology nurses, frustrated by hospital working conditions, followed their medical oncology colleagues to community practice settings and enjoyed more collaborative practice, less arduous work hours, and less bureaucratic oversight. And for patients, having care closer to home with their chemotherapy administered in an office

setting rather than a hospital was far more preferable.

## Changing times

For many years, community oncologists enjoyed favorable reimbursement from the Center for Medicare and Medicaid Services. But recently, in conversations with my medical oncologist colleagues, it's clear the current reimbursement rates for chemotherapy administration and related care challenge the existing business model. Stagnant reimbursement schedules by Medicare and other payers force practices to make tough decisions in order to remain financially viable. Oncologists are considering strategic alliances, purchasing cooperatives, joining for-profit corporations, and using consultants to trim expenses. If this sounds familiar, it's because these strategies are identical to the ones adopted by chief executives of hospitals and health systems in the late 1990s.

For the sake of patients and providers, let's hope that the results of these strategies pan out differently for community oncology. This is possible if medical oncologists and practice administrators consider the following as they create proactive solutions for their practices:

**Can we do any better with our existing resources?** For example, are employees such as physicians and nurses stuck in paperwork when they should be seeing patients? Can a well-trained, proactive administrative assistant help these professionals spend more time with patients than with fax machines and telephone calls?

**Have we standardized care?** To avoid time-consuming com-

munication between providers, are standing orders for common patient symptoms or supportive care needs in place to allow providers more time with patients?

**Can purchasing of supplies and medications be made more efficient?** Purchasing should accurately reflect the needs of the practice and optimize inventory. Perhaps a strategic purchasing cooperative should be considered.

**Have we consulted with our fellow practitioners about proposed changes?** How will the changes affect their practices? What can be done to support our colleagues? What ideas do they have that could be helpful?

**What will these changes mean for our patients?** Will this better focus care on their needs, increase their satisfaction, and prevent their risk for error or complication? If this cannot be predicted, we'll need to review our changes, evaluate them, and alter them, if necessary.

## Learning from the past

These considerations were glaringly absent from the business decisions made by hospitals in the late 1990s. As the author Dana Weinberg wrote, the "Code Green" enacted by hospitals was meant to resuscitate the bottom line, and not help ailing patients.<sup>8</sup> By making smart business decisions that consider the needs of patients and providers, community oncology practices can avoid the pitfalls, retain their experienced registered nurses, and optimize patient outcomes.

What's needed is careful evaluation as you go. If a strategy isn't working, an interim analysis will show that you need to make course adjustments.

It's analogous to a data safety monitoring board for clinical trials that issues progress reports. Keep monitoring the situation. Only in that way can we avoid the mistakes of the past.

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