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Sustaining Clinical Programs During Difficult Economic Times: A Case Series from the Hospital Elder Life Program

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Abstract

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OBJECTIVES—To explore strategies used by clinical programs to justify operations to decision-makers using the example of the Hospital Elder Life Program (HELP), an evidence-based, cost-effective program to improve care for hospitalized older adults.

DESIGN—Qualitative study design utilizing 62 in-depth, semi-structured interviews conducted with HELP staff members and hospital administrators between September 2008 and August 2009.

SETTING—19 HELP sites in hospitals across the U.S. and Canada that had been recruiting patients for at least 6 months.

PARTICIPANTS and MEASUREMENTS—HELP staff and hospital administrator experiences sustaining the program in the face of actual or perceived financial threats, with a focus on factors they believe are effective in justifying the program to decision-makers in the hospital or health system.

RESULTS—Using the constant comparative method, a standard qualitative analysis technique, three major themes were identified across interviews. Each focuses on a strategy for successfully justifying the program and securing funds for continued operations: 1) interact meaningfully with decision-makers, including formal presentations that showcase operational successes, and also informal means that highlight the benefits of HELP to the hospital or health system; 2) document day-to-day, operational successes in metrics that resonate with decision-maker priorities; and 3) garner support from influential hospital staff that feed into administrative decision-making, particularly nurses and physicians.

CONCLUSION—As clinical programs face financially challenging times, it is important to find effective ways to justify their operations to decision-makers. Strategies described here may help clinically-effective and cost-effective programs sustain themselves, and thus may help improve care in their institutions.

Keywords

Hospital Elder Life Program; cost-effectiveness; sustaining programs; hospital administration; clinical innovations; quality of care; delirium prevention; acute care; geriatrics

INTRODUCTION

Past research suggests it is difficult to sustain new clinical programs, especially in geriatrics, where interventions are often multi-faceted and require change across multiple care processes.[1,2,3] In difficult economic times, new clinical programs may face even greater challenges, including increased scrutiny from hospital administrators and other decision-makers as they look for opportunities to cut costs.

The medical literature has little to guide clinical programs in sustaining themselves, with even less focused on the particular issue of ensuring long-term support from hospital administrators.[3] Studies on clinical innovations have largely focused on the issue of innovation adoption, rather than sustainability,[4,5,6,7] with a very limited discussion of "human technologies" (defined by Bradley as "innovations that are multifaceted, require coordination across disciplines and are not traceable to a specific new technology, and involve substantial attitudinal shifts among staff"[3]). The quality of care improvement literature has a greater focus on human technologies, but is similarly focused on adoption rather than sustainability.[8] Further, while the research identifies organizational characteristics associated with the adoption of improvements even in the field of geriatrics,[9,10,11] the process by which these characteristics lead to the adoption or continuation of a program is largely a black box, with little information to shed light on the processes involved.[12] Thus, there is very little evidence-based, practical information to

guide the clinician in steps to improve the likelihood that a program will survive on a long-term basis. Available information speaks more to accounting details of the process rather than the staff and organizational issues.[13]

This article addresses this gap in the literature by examining staff and operational strategies that clinical programs utilize to justify a program's operations and budget to decision-makers. To provide a practical and detailed view, it utilizes a case study approach focused on the Hospital Elder Life Program (HELP). HELP is an innovative, hospital-based program to prevent delirium and functional decline in hospitalized older adults, and it is currently operating in approximately 100 hospitals in the United States and 7 countries worldwide. HELP utilizes a multi-disciplinary team and trained lay volunteers to deliver a series of interventions to older patients. These interventions include: daily visits and orienting communication, therapeutic activities, assistance with mobilization, assistance with feeding and hydration, monitoring and correction of vision and hearing deficits, and assistance with sleep. HELP serves as an excellent model for such a study because it has several characteristics that are likely to be attractive to decision-makers. For example, it has been shown to be both clinically effective and cost-effective, saving approximately $800 per enrolled patient and diminishing costs of long-term care.[14,15,16,17] The program has also been shown to improve nursing satisfaction as well as patient and family satisfaction.[18] Moreover, HELP is useful for prevention of Medicare no-pay conditions.[19] At the same time, HELP staff cannot rely exclusively on this literature to justify operations because each program is adapted to a unique clinical setting where decision-maker priorities may vary.[3] Thus, as with new programs in many settings, each site must explicitly or implicitly justify their unique program to local decision-makers.

METHODS

Design and Data Collection

Data utilized in this analysis come from a qualitative study of 19 active HELP sites in hospitals and health systems in the United States and Canada that volunteered to participate. Eligible sites for this study included those with a formal HELP contract, an identified liaison, and actively enrolling patients for at least 6 months by the time of the first interview.

Because budgetary decision-making processes in hospitals are often diffuse and complex,[20] researchers interviewed people involved with HELP in a range of capacities, including administrators, physicians and nursing staff, to provide multiple perspectives on efforts to justify the program to decision-makers. To identify participants, researchers used a "snowball" recruiting methodology , which is a particularly appropriate approach for the study of small populations such as this one.[18] For the "snowball" method, the first step was to recruit the main contact person, or HELP liaison, at each site, who then recommended up to 3 additional people at the site to complete an interview. At the close of each subsequent interview, participants were asked to identify others who would be appropriate for interviewing and so on. Interviews continued at each of the sites until all persons identified through this process had been contacted.

Researchers trained in qualitative interviewing techniques conducted semi-structured, in-depth interviews with each participant over the telephone. The interviewing process was based on standardized techniques considered to enhance the quality and comparability of qualitative research efforts.[22,23] The interview guide was developed principally with open-ended questions addressing the major topics, and then follow-up questions and probing techniques were used to round out the responses from participants. Through these interviews, participants described their experiences in HELP with a particular focus on the challenges they faced, as well as the strategies that helped them address these challenges, in

trying to justify the program to key decision-makers, defined generally as those with funding-related authorities for staff or resources. Participants commented on their own activities, as well as those of other HELP staff and hospital or health system administrators.

Interviews lasted between 45 and 75 minutes, and in one case a participant requested a second interview that extended the discussion another 30 minutes. Where possible, interviews were audiotaped and then transcribed by an independent, professional transcription team with subsequent review by a research team member for accuracy. All participants provided oral consent before beginning the interview. The institutional review boards (IRB) at Hebrew SeniorLife and the Harvard School of Public Health approved all research procedures.

Data Analysis

Analysis of these data relied on the constant comparative method, a standard qualitative analytic technique,[24,25] through which researchers developed a systematic synthesis of thematic elements in the interviews that described the primary strategies through which HELP sites justify their programs to key decision-makers. Researchers utilized a sample of approximately 15 interviews to develop an initial code list, and then refined this code list through multiple iterations until they reached thematic saturation as they continued to review interviews. The full research team reviewed the codebook to ensure logic and comprehensiveness. Decisions about the codebook were achieved through consensus of the primary coders and project director. Utilizing the finalized codebook, two members of the research team coded all of the interviews in Atlas-ti (ATLAS.ti GmbH, Berlin, Germany). This state-of-the art software is designed explicitly for qualitative research and facilitates not only the constant comparative method during codebook development, but also the identification of related themes and relevant quotations. Coding resulted in 24 interrelated themes that were organized into three major areas. During the initial stages of analysis, it was apparent that data from participants in different roles were consistent with each other, and thus, all data were analyzed together.

RESULTS

Sample Characteristics

Of the 23 eligible sites, 21 participated in the study. One site did not qualify (i.e., had not been recruiting patients for at least 6 months) and one refused to participate due to time constraints on staff. Thus, 96% of the qualified and identifiable sites participated. During the course of the study, two HELP sites that initially agreed to participate were closed and could no longer participate. The final list of 19 study sites included those located in hospitals and health systems that vary with respect to size, geography, ownership status and teaching status. (See Table 1). Programs had been enrolling patients for 4.5 years on average (range of 1.2 to 7.5 years) at the time of their interviews, and all the sites received some funds from the hospital where they were located. Typically, the hospital covered the cost of staff salary and benefits, while donations, grants and other fundraising supported the program materials, including hearing amplifiers and games, for example.

Researchers attempted to conduct interviews with 72 people across sites. Three people had left the program; one declined to participate because he did not feel he had sufficient experience with HELP; one refused due to time constraints; and five never replied to multiple invitations by email and phone. Thus, 62 completed an interview, which is a 91% response rate among qualified participants still involved in HELP programs. Interviews included a range of 2-5 staff members at each site who were grouped into 2 overarching categories (See Table 2). There were 20 people (32%) at 15 sites who were considered

"influencers" because of direct or indirect involvement in the decision-making relevant to the HELP budget and who typically had closer relationships to the senior administrative team, such as the president or Chief Executive Officer (CEO). Participants in the category of "influencers" included administrators and managers serving in roles such as the Chief Nursing Officer or the Director of Rehabilitation, as well as physicians who had managerial responsibilities and served in roles such as Department Chair, Program Chief, or Medical Staff Director. There were 43 participants (68%) at all 19 sites who fell into the second category, which we call "frontline staff." These included people serving in roles such as the Elder Life Specialist or Elder Life Nurse Specialist (typically an advance practice geriatric nurse). Individuals in this latter category had little direct involvement in the budgetary decision-making process, but frequently indicated that managers, administrators and physicians they worked with had discussed the decision-making process with them explicitly.

Influencers typically had more in-depth information about the strategic priorities of senior administrators, materials they would find most compelling when considering whether or not to fund the HELP program, and the nature of meetings with senior administration about the HELP program. By contrast, frontline staff typically had more in-depth information about how HELP staff supported influencers' efforts to reach administrators through day-to-day operations, such as report preparation, data collection and interaction with other staff. However, the comments of these two categories of participants were complementary, and in some cases they also overlapped considerably. Influencers described what frontline staff did and frontline staff also described what influencers did and what they learned about the views of senior administrators. Thus, data from both of these populations are presented together in order to give readers a broad perspective on the strategies HELP programs used to reach decision-makers (Table 3).

Major Themes Related to Justifying the Program

Analysis revealed three major themes related to what participants reported as effective efforts to justify the program to key decision-makers. First, sites interact meaningfully with decision-makers, not only formally through presentations that showcase operational successes, but also informally in ways that highlight the benefits of HELP to the hospital or health system. Second, sites document their day-to-day, operational successes and estimate their impact in terms of metrics that resonate with decision-makers. Third, sites garner support from staff who are critical to administrative decision-making, particularly nursing staff and physicians. Each of these themes and activities is described below. In addition, Table 3 presents further practical strategies to address each of the themes.

Interacting Meaningfully with Decision-makers

HELP program staff make use of multiple means for interacting with decision-makers. For example, HELP program staff sometimes present formally to decision-makers, with prepared materials in PowerPoint or written text form during regularly scheduled and highly-structured meetings, such as annual departmental or program reviews. Performing well in these high-visibility meetings is critical. Factors that facilitate effective performance include: adhering to formal guidelines (e.g., number of slides); keeping it brief as a general rule; and presenting data that is compelling to administrators and non-clinical hospital leaders.

Much of the success in formal settings derives from earlier, informal connections with decision-makers. These not only help staff know how to present materials in the formal setting, but also make broader connections. Examples of informal connections include meetings about other topics such as committee meetings, in which HELP staff or supporters

are able to bring up the issue of HELP, but also able to garner feedback from decision-makers about their general priorities and about their views of HELP's benefits to the hospital or health system. Participants felt that interactions went far beyond formal presentations to include true relationship building and require vigilance to ensure the relationships maintain even during difficult times. While "influencers" were generally more likely to be focused on relationship-building, frontline staff were nonetheless involved in meetings with persons who would be indirectly involved with the most senior decision-makers, such as quality improvement committees or geriatric service committees, in order to enhance visibility through these channels as well.

Often, senior HELP staff or "champions" of the program participate in informal meetings with the most senior decision-makers, and the champion's position facilitates the interactions. This person may know the senior decision-makers so well that she or he can even anticipate their needs or speak to them in the most casual settings that allow them to make a stronger case for maintaining HELP. For this reason, having a reporting structure in which HELP staff report to senior administration directly can be helpful.

In addition to direct interactions with senior decision-makers, HELP programs may bolster their relationships with more traditional public relations techniques to reinforce the idea that the HELP program is successful, well-received within the hospital/health system, and reflecting well on the hospital or health system to outsiders and competitors. They may do this on their own, or rely on the public relations group at the hospital or health system. Aside from publishing their own newsletter or writing stories for the hospital newsletter, there are less traditional approaches as well, including internal publicity events like health fairs or conferences and the presentation of data. Sometimes sites also benefit from traditional press coverage of hospital and program events such as fundraisers

Documenting Successes in Metrics that Resonate with Decision-Makers

Determining which data to collect is, in part, influenced by practical necessities such as what data is feasible to collect. It is also a strategic choice because successful HELP programs collect data to document their achievements in terms of outcomes that are meaningful to decision-makers. They determine which metrics will resonate through interactions with the decision-makers as described above, but also with more generalized views of what is likely to be important based on the hospital or health-system's broader priorities. The factors most generally documented with quantifiable data fell into two categories: 1) Metrics that document the extent of care or services provided by the HELP program, including the protocols they provide, the number of patients they see, and how long they provide services to them; 2) Metrics that demonstrate the impact of this care or services on a) health outcomes (e.g., Did we reduce delirium? Did we reduce falls?); b) the impact on costs (e.g., Did HELP reduce costs or factors that indicate costs, like length of stay?); c) the impact on patient satisfaction or staff satisfaction (e.g., Did HELP improve satisfaction?)

While there may not be an explicit invitation to submit such data, successful programs consider such reporting a top priority. Many assume that formal documentation is required, even if it is not explicitly stated, and others note that they collect the data or even submit it even if such information is not requested for the current year.

Further, even if senior decision-makers have asked for general information, HELP staff may include financial measures because financial goals are often an implicit priority.

Documenting these measures requires more time or expertise than staff typically have, and although it can be part of HELP staff job descriptions, this is not uniform. Extra staff hours are pulled in through volunteers, students, interns, and some unpaid hours. Several sites have

developed ongoing relationships with nearby universities in order to ensure a steadier supply of students and interns. Gathering data that is housed in other places, such as 'length of stay' or financial data, often requires assistance of other persons that may work in other departments, including quality management, information technology, or finance. Champions can be helpful in getting their involvement. Analysis of the data typically involves someone with more statistical or data management skills than staff may have, so staff may rely on persons in these other departments or they may turn to students or interns, or even some untraditional partnerships with volunteers who have these skills. Alternatively, if staff have the data skills themselves, they may pull in interns to take on other responsibilities while they focus on the data.

In addition to quantifiable data, HELP programs also collect anecdotal evidence of their success. Descriptions of the ways that staff or volunteers support patient care, or excerpts from patient or family letters of thanks help decision-makers understand the value of HELP in human terms. They put the quantifiable data in context that may better articulate how the HELP program supports the hospital or health system's larger goals. Such information can also be important in making a stronger case to senior decision-makers, especially those with clinical backgrounds, because it can showcase the compassionate aspect of the program.

Finally, HELP staff also show that HELP supports other important hospital goals, including 1) sustaining the hospital or health system mission and 2) strategically positioning the hospital or health system in the competitive arena of other area providers. Situating HELP inside this package makes clear to decision-makers that the HELP program benefits the hospital or health system. For this reason, having a hospital that has a focus on geriatrics either as a mission or as a strategic positioning against competitors makes the job easier for HELP sites.

Garnering Support from Influential Hospital Staff

Successful HELP programs garner support from influential hospital staff aside from decision-makers in order to ensure that senior staff or clinicians know about the program and its positive impact, to preempt any unforeseen obstacles to long-term program survival, and to create a positive "feel" about the program that can reach decision-makers indirectly.

Reaching out to nurses is a priority for successful HELP sites. Strategies for doing so include not only having discussions with the head nurse for a department or relevant shift nurses, but also providing true services to the nursing team as a whole. This may include training sessions on geriatric care for new hires, for example. The frontline staff, who are often nurses themselves, use frequent one-on-one discussions to ensure that their services are seen as helping nurses rather than overriding them or adding to their workload.

In some cases, HELP programs have gone so far as to operate parallel programs that do not officially enroll HELP patients. In these cases, the program provides the "friendly visits" and other pieces of the HELP protocols that assist nurses with their workload and reassure them that their patients are receiving compassionate care, even when they are busy.

Reaching out to physicians is also important insofar as some of the physicians have a more direct connection with key decision-makers, and hospital decision-makers may be interested more generally in physician perceptions of hospital programs. HELP staff and supporters provide some formal services, including presentations at grand rounds and training sessions for medical students/trainees or for sitters/companions in HELP principles and geriatric care, but they also emphasize the importance of individualized interactions with doctors to ensure that the physicians do not feel the program is overstepping its bounds or being critical of

existing care practices. The physician on the HELP staff has a particularly important role to play here.

HELP staff and supporters maintain positive relationships with ancillary staff to ensure effective operation of the program, but these relationships play a lesser role in connecting with key decision-makers at some institutions. Nonetheless, formal trainings as well as interdisciplinary meetings provide key opportunities to garner ancillary staff support and generate broader support for the program.

DISCUSSION

Staff and administrators at 19 successful HELP programs in the United States and Canada have identified three interrelated processes that they believe help them justify, and therefore sustain, the program to key decision-makers: 1) interact meaningfully with decision-makers both formally and informally; 2) document day-to-day, operational successes and estimate program impact in terms that resonate with decision-makers; and 3) garner support from hospital staff who are influential in administrative decision-making.

The processes outlined in this research are not easy to undertake, and they require investment of staff time and resources. For example, reaching out to supportive clinicians through training sessions, or running an informal program to address specific nursing needs, can require substantial staff time. Programs may need to anticipate ways to support staff who feel they are doing ‘extra’ work for such efforts. Data collection is also a time-consuming task, but perhaps more importantly, requires somewhat sophisticated analytic and computer skills. Staff who have such skills are an asset for programs; programs that do not have these resources in their own staff may need to look at creative partnerships, including relationships with other hospital departments or nearby universities, in order to build this capacity.

The processes outlined in this research also requirelong-term commitment and perseverance, given the nature of data collection and relationship development. For example, although setting up data collection may have to happen early in the process, small programs may need to collect data for several months or longer, in order to show impact. In addition, it may take many meetings before the new program regularly appears on the agenda, such as of departmental meetings. The processes identified here are consistent with the approaches successful programs may take during implementation, even if they require programs to take additional steps after that phase in order to cycle through the justification process. [4,5] Nonetheless, planning for later stage efforts even during the implementation phase may be wise. Thinking ahead in this way is consistent with theoretical work in the area of implementing clinical programs.[26]

A theme underlying the description of each of these steps is the idea that justifying the program to decision-makers may also take a shift in mindset – from daily operations to longer-term, strategic planning. Programs cannot simply collect data they believe is important, but must also try to anticipate the current and future needs of the hospital from the eyes of decision-makers. In a similar vein, they cannot provide only the services or care they believe are important, but instead must try to understand unmet clinical needs locally, and then make sure the program addresses them.

There are limitations to this study, given that it is based on an extended case study of a single hospital-based model of care. The findings may not be applicable to other healthcare settings, particularly those with very different decision-making structures and processes, such as outpatient or institutional care. Further, the study did not include decision-makers at all of the sites, so it laid emphasis on what the frontline staff and physicians believed was

important. However, the perspectives of these front-line staff proved quite useful in contributing to practical recommendations for future sites. In addition, all of the sites had maintained funding for long enough to recruit patients (which can take several years), so their ideas had engendered some success. We did not see any substantial differences in approach between those programs that were newer and those more established.

Despite these limitations, the findings from this study may help similar, hospital-based programs be successful over time. Importantly, this study fills a key gap in the literature. To date, very little research has been done on sustaining programs in general, or in the current difficult economic times. Thus, this study provides vital and practical information to assist program developers and clinical innovators with strategies that have face validity and that will likely be generalizable across programs and settings. Future research may be beneficial to examine areas not addressed in this effort, including the experiences of sites that have closed. Such research may shed light on additional issues that influence site success, including funding source and amount as well as the broader hospital environment.

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Table 1

Characteristics of Study Hospitals

Country or Region	Geographic Area	Staffed Beds*	Ownership	Teaching Status	Years Running	Funding Sources
Northeast	Urban	800	Non-profit	Teaching	5.4	hospital funding, external grant
Northeast	Urban	600	Non-profit	Teaching	6.8	hospital funding
Northeast	Urban	400	Non-profit	Non-teaching	3.3	hospital funding, external grant
Northeast	Urban	200	Non-profit	Teaching	6.7	hospital funding, external grant, donations,
Northeast	Urban	500	Non-profit	Teaching	7.5	hospital funding, external grants
Northeast	Suburban	600	Non-profit	Teaching	5.8	hospital funding, internal grant
Northeast	Rural	600	Non-profit	Teaching	1.8	hospital funding
Midwest	Urban	800	Non-profit	Teaching	6.6	hospital funding, internal grant
Midwest	Urban	600	Non-profit	Teaching	4.5	hospital funding, external grant, donations
Midwest	Urban	500	Non-profit	Teaching	4.9	hospital funding, donations
Midwest	Urban	200	Non-profit	Non-teaching	5.8	hospital funding, donations
Midwest	Suburban	100	Non-profit	Non-teaching	3.0	hospital funding, external grants
South	Suburban	800	Non-profit	Teaching	4.0	hospital funding, fundraising, donations
South	Rural	100	Non-profit	Non-teaching	1.4	hospital funding, fundraising
Canada	Urban	500	Non-profit	Teaching	1.2	hospital funding, external grant
Canada	Urban	400	Non-profit	Teaching	4.4	hospital funding, donations
Canada	Urban	300	Non-profit	Teaching	7.5	hospital funding, donations
Canada	Suburban	300	Non-profit	Non-teaching	2.6	hospital funding
Canada	Suburban	300	Non-profit	Non-teaching	2.5	hospital funding, external grants, donations

United States Regions: *Midwest* – ND, SD, NE, KS, MO, IA, MN, WI, MI, IL, IN, OH; *Northeast* – ME, NH, VT, MA, CT, NY, RI, NJ, PA; *South* – TX, OK, AR, LA, MS, AL, FL, GA, SC, NC, VA, TN, KY, WV, MD, DE; *West* – WA, OR, ID, MT, WY, CO, UT, NV, CA, AZ, NM; *Pacific* – AK, HI.

*Approximate numbers

Table 2

Interviewees by Category

Influencers*	
Administrator	12
Senior Physician	8
Frontline Staff	
Program Director**	4
Elder Life Specialist***	20
Elder Life Nurse Specialist****	18
Total Interviews	62

* "Influencers" have direct or indirect involvement in the decision-making relevant to the HELP budget and typically have closer relationships to the senior administrative team, such as the president or Chief Executive Officer (CEO). Participants in the category of "influencers" included administrators and managers serving in roles such as the Chief Nursing Officer or the Director of Rehabilitation, as well as physicians who had managerial responsibilities and served in roles such as Department Chair, Program Chief, or Medical Staff Director

** Program Directors are typically trained staff who oversee HELP operations and may coordinate efforts across sites within the same health care system. They typically have a nursing background.

*** Elder Life Specialists are specially trained staff members who coordinate the implementation of HELP interventions, train and coordinate volunteers, assess patients, assign interventions, and track HELP data. They typically have a BA or MA degree, and come from diverse backgrounds in healthcare and related fields, such as gerontology, psychology, social work, or therapeutic recreation.

**** Elder Life Nurse Specialists are typically advanced practice geriatric nurses who provide clinical nursing assessments, implement nursing protocols, coordinate interdisciplinary rounds, interface with other clinicians, conduct nursing in-services and oversee effective discharge.

Table 3

Select Quotations from "Influencers" and Frontline Staff

Influencers	Frontline Staff
Task A: Interacting Meaningfully with Decision-Makers	
The Nature of Formal Presentations	
" **It is not a very long presentation - it is 15** *minutes or 20 minutes. This committee…is charged with some fairly important things and they are following a lot of QI projects, so we want to put it together in a way that is well laid out and easy to follow…We usually do a short review of about three or four minutes just playing into the background of the HELP idea, and…[then we discuss] what the data is, and what evidence [there] is for these interventions, and who is involved, and what process we go through to select people and then administer it."*	*"I guess [our physician] knew the CEO and knew the style of how [presenters at meetings] talked about other issues in the hospital…The [standard] style was a…PowerPoint presentation with…statistical data of the background, the findings, and then qualitative examples of case studies. So, it was about a 20-slide presentation."*
Building Relationships with Decision-makers and Increasing Visibility Informally	
"It is all about creating relationships…We try to maintain relationships with…VIP people and various nurses that we know are making decisions about this. And…we went to every meeting because…sometimes you are not at a meeting and things get overlooked." *"These are people I have been working with for a number of years. These are people who knew what we were trying to do in terms of improving care of the elderly….Talking to these folks was having an ongoing conversation with people, I was already dealing with who already understood, who already got it that we were trying to improve care of the elderly."*	*"[Attending committee meetings] definitely promotes [HELP] and keeps it uppermost in the minds of any of the stakeholders that are dealing with seniors in the hospital setting and…community."* *"I am expected to sit on committees more and more so because we are now with the joint commission mandates about pressure ulcers and reimbursement…So geriatrics is playing more and more a piece of it…[And] I am more noticed."*
Influencers	**Frontline Staff**
The Role of the Champion in Maintaining Informal Relationships	
"Whenever there is a change in leadership that has been one of my role to make sure that they know who I am and know about this program.…If there is not somebody in the organization that can do that for HELP, HELP is going to be in jeopardy." *"[The Elder Life Specialist] reports directly to me…so she can get the support she needs for the program…If she runs into a glitch - rather than have her go through a maze - …she just comes to me [and] then I will intervene…[I can go] to the CEO and explain… the benefits…to the organization in terms of…getting patients out of the hospital a bit sooner."*	*"We…showed [our last data report] to the director of nursing….It was not any formal meeting or anything…but my manager, she always makes a point of mentioning it to anybody. If her boss is visiting us, she would mention it….If a doctor stops by for a conversation or the CEO stops by, she would always make a point of mentioning about our progress."* *"The director had already built up a relationship with the CEO and just had political power in the institution and political ties to people and the board and the in-house foundation, so he was already involved with getting the word out."*
Using Public Relations Techniques	
"We had…a little [radio] program about HELP…and they were answering questions and…the radio announcer…said, 'I know all about the program; my father was involved in it.' It was excellent – I mean he shared that on the air!" *"We have entered the hospital quality fair…and won the grand prize….So that gets*	*"When we do research or present [data] at different…conferences, the administration is very much aware of that. The program director will email our presentation…to Board administration… The CEO…the Vice-President of nursing…the assistant Vice-President of nursing services…and [the medical director]…They've e-mailed 'Great*

Influencers	Frontline Staff
us some publicity.	*job!' or something like that back."* *"Recently, the site was [given an] award, and the chief medical officer was very excited and announced that at the key personnel meeting and then it was posted prominently on the home page of the hospital. [Based on] the nice letters from the chief medical officer of the system, [I think] the hospital does recognize the value of the hard work of the volunteers and of the HELP Program."*
Influencers	**Frontline Staff**
Task B: Documenting Successes in Metrics that Resonate with Decision-Makers	
Focusing on Data that Reflects Decision-Maker Priorities Even without an Explicit Request for the Information	
"I would say I always feel pressure to continue to demonstrate our value to administration every single year in not only clinical outcome terms - meaning reducing delirium, improving patient satisfaction, or improving nursing satisfaction,, but also to show some estimate of financial outcomes in terms of reducing cost and reducing length of stay. As somebody who is also a manager myself I imagine that it is important without them saying it to me." *"They never said that they wanted me to save cash, but I really think they did, which is the nature of administrators…Of course, the big rhinoceros in the living room is the current financial crisis that all America has gone through. We have had layoffs at this hospital. We have had programs that have been discontinued or cut way back, so I always worry, 'Could they decide we cannot afford to do HELP anymore?'"*	*"Because we have to be able to show outcome figures, we have to speak financial language….and not just collect this data and say, 'Well, that is really great.' Finance does not care about whether the Foley comes out or not or whether the patient gets out of bed or not. They need to see patient outcomes that can be translated into dollars and cents."* *"What [the program] is and the good name and the good work is always frosting on the cake, but the cake is what they are really looking at. So we had to prepare for a way for them to do a financial analysis."*
Using Creative Staffing for Documentation	
"We did a student project looking at data from the patients that we had enrolled…And, [we] had one social work intern who was involved for a couple of years helping to do the training and to do the actual assessment of the patients. We have a fairly robust social work department that we are affiliated with and they have a lot of social work interns rotating through regularly." *"We have our own sort of computer person. He is actually [a personal friend] of a staff member…He is not employed by the hospital, but he is very good at doing things like manipulating Access databases and creating queries."* *"There is a department of decision support in this organization and these are analysts that work for the organization and they have been given permission to work with me."*	*"I have school of social work interns…so that part of the savings in salary is that I have two interns - they are essentially my left and right hands."* *"We had a first year medical student…[and] she did some research…She was able to demonstrate that we did make a difference with improved mobility and improved hydration and improved cognition at the time of discharge."* *"[We got help from] somebody who had injured herself in the hospital, not a nurse but [someone] very good at IT….She helped me do the whole computer thing, because I did not have the dedicated time to do the original [work] year to year…It is hard and we do not have any IT support here; it is impossible….She was on "comp" [compensated time]. She had injured [herself]…[and] that is how we got her."*
Influencers	**Frontline Staff**
Utilizing Non-financial Metrics and Non-quantifiable Data	
"I think people are impressed by *the…compassion and caring feeling that volunteers are able to give to this program, and I think that [is revealed in] data from*	*"[The administration] did realize that we were doing something good. We had a lot of personal feedback from patients and letters written to the CEO."*

Influencers	Frontline Staff
our patient satisfaction records." *"I think that is gives us the different opportunities for a different type of recognition that other facilities would not have….There is a lot of competition [with nearby hospitals] in other geriatric services, so we would like to be able to capitalized on what do we have that is physically unique to us."* *"I think that satisfaction alone would not have justified this, but showing the reduction in delirium incidents and satisfaction with patients and nurses and the volunteer of the year was someone with the HELP Program, which showed that the volunteers were active in doing things much more purposeful than many others - all of these were very compelling."*	*"[They] had these focus groups and they actually made a video, which was awesome. Some of [the participants] were elders themselves, some of them were spouses of the elders or family members, and it was unbelievable."*
Influencers	**Frontline Staff**
Task C: Garnering Support from Influential Hospital Staff	
Reaching out to nurses	
"When we started this program, the nurses [essentially said], 'We're not going to help you with that.' Now they see the HELP volunteer and they [say] 'Oh could you go and visit this patient? You know, they might not be a candidate for HELP…but at least there would be a visit if (a volunteer) could go…and talk with that patient for a while.' So it is the buy-in of the staff itself."	*"When (the nurses) call, we try to be there and establish credibility…It is very important, because…they have been so disillusioned and they have been promised so many things."* *"It is really a delicate balance to do what we have to do and not make the nurses think that we were doing their job or checking up on them. [We try to explain that] this is more like a system issue…Nurses are so busy…and we want the nurses to think:… 'We are not replacing you; we are just an extension of you.'"* *"We have done smaller in-services and things. So far, we have geriatric rounds once a month. Then we invited many of the nurses who can attend and the HELP Program is often mentioned in those meetings. We have different celebrations throughout the year where we highlight the HELP Program and we now…have what we have been calling the 'helper of the month.' [These are staff who] are identified by [HELP staff] as people who are particularly good at caring for geriatric patients and we take their picture and we write a little blurb about them and we also put it in 'nursing notes' [newsletter]…and we have a 'geriatric corner' in the nursing notes where we have a little article that we try to put in there about caring for geriatrics. We also have the benefit of having a state grant, a labor and industry grant where we have trained 70 or 80 nurses in geriatric care."*
Influencers	**Frontline Staff**
Reaching out to doctors	
"I think having the medical staff on board - at least in this facility - is vital because the medical staff is a strong driver of programs in this facility….There is a strong presence of the HELP staff every week at grand rounds….There is ongoing communication with the medical staff in terms of [each patient]…Also, the HELP team is not isolated on the HELP program, they serve on other committees where they are visible	*"I have learned code words, I have learned how to say nicely, 'Please order this test, if not already done' [for example]. There are survival techniques for a nurse practitioner in the hospital….To say it nicely so that doctor does not feel that he is made to like he has missed something."*

Influencers	Frontline Staff
in hospital. So for example, we have a pressure ulcer prevention team that the nurse practitioner and the nurse from HELP strongly support, and they are visible during those presentations as well."	
"We gave talks two weeks ago at grand rounds, which is the whole Internal Medicine Department …and so this gives the [information to] administration because the chief of medicine attends these. The chief residents, a lot of the attendings on medicine, and other specialties come to these rounds, as well as all of the house staff…and medical students…. So that is a very powerful place to present it….This is how the word gets out, but it takes quite a lot of continual educating to keep reminding people about this."	
Reaching out to ancillary staff	
"We also collaborate with our physical therapy department for training physical therapy students, which they like a lot….We have some PT students who are also HELP volunteers who actually get to do more hands on [work] with us then they would wearing their hat as a student."	*"Now people approach us a lot more because we have established some really good support through different disciplines - physiotherapy and occupational therapy…social work as well. When…the frontline staff…see the value of what you are doing, they are the ones that are going to start talking you up to other people and the higher-ups, and so…it becomes word-of-mouth."*

Table 4

Tasks That Successful Programs Undertake to Justify Operations to Key Decision-Makers

A: Interact meaningfully with decision-makers

- Use formal presentations to present compelling data (e.g., short PowerPoint presentations that follow hospital or health system standards)
- Use informal discussions and meetings about subjects other than the program (e.g., quality committee meetings) to identify decision-maker needs, create relationships, and maintain visibility
- Garner input from senior staff "champions" who may have other relationships with decision-makers and know the cultural norms of interactions
- Participate in important events, like health fairs or conferences, that may be covered by hospital/health system newsletters to generate a positive impression of the program that can filter up to decision-makers
- Create your own media using newsletter submissions for internal recognition
- Consider public media, like local newspapers or talk radio shows, to cover your fundraising or other events in order to get more attention and reach decision-makers

B: Document day-to-day, operational successes and estimate program impact in terms that resonate with decision-makers

- Determine the best data to collect by considering the priorities of decision-makers; leverage input from knowledgeable champions when possible
- Collect data that will show how much work has been done in terms of patient care (e.g., number of patients served, number of interventions completed)
- Obtain data to show the impact the program has in terms of finances, patient satisfaction, and staff satisfaction
- Supplement paid staff hours for data collection and related efforts by using interns, students, and even hospital resources like staff in the quality improvement office
- Utilize patient and family surveys to gather more personal stories about the way the program has touched patient and family lives
- State in clear words on any reports how the program fits the hospital or health system's mission or strategic plan

C: Garner support from audiences that feed into administrative decision-making

- Identify the needs of staff and physicians who will interact with the program in order to ensure their buy-in and help generate positive word-of-mouth about the program
- Develop materials that support staff education needs while showcasing the program (e.g., training for new hires or continuing education modules)
- Consider the feasibility of conducting related projects that assist staff and physicians even if they are outside the scope of the original program (e.g., patient support programs that address nurses' concerns)