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Abstract: This paper examines the topic of multiskilling in three areas: (a) healthcare trends that drive the need for multiskilling, (b) perspectives from the multiskilling literature, and (c) a case study describing the use of multiskilling and patient-focused care in one organization. Trends facing healthcare providers include cost containment, mergers and alliances, and consumerism. Integrated, these trends cause a fundamental reshaping of the field. One strategy that healthcare providers are using to adapt to the changing business environment is multiskilling. This strategy can lower costs, facilitate collaboration among those providing care and increase patient satisfaction.

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A Specialist is someone who knows
more and more about
less and less

A Generalist
knows less and less
about more and more

A growing number of healthcare executives say that the beleaguered industry can no longer afford a workforce composed of too many types of specialized technicians, many of whom are in short supply and protected by state legislative acts that regulate allied health professions. Critics of the current system are quietly shaping a radical solution to the problem: multiskilling. The idea, which healthcare executives have modified from a strategy created for high-tech manufacturing, is to train technicians to perform multiple tasks so they can be deployed more efficiently (Perry, 1991). This paper examines the topic of multiskilling in three areas: (a) healthcare trends that drive the need for multiskilling, (b) perspectives from the multiskilling literature, and (c) a case study describing the use of multiskilling in one organization.

Healthcare Trends That Drive the Need for Multiskilling

The trends that provide the impetus for multiskilling include cost containment, mergers and alliances, and consumerism. The first trend, cost containment, is currently receiving press in relation to healthcare reform. Previously, advancements in medical technology and patient care drove change. Today, the financing of healthcare to control costs drives change (Healthcare Advisory Board, 1994). For example, the days of adequate reimbursement have been replaced with meager reimbursement and shortfalls. Further, the cost shifting that once provided a financial cushion has been limited by cavitation, and fee for service payment has

given rise to managed care, discounts, and cavitation. Such cost containment strategies have changed the business environment for healthcare providers from one of stability, predictability, and financial strength to one of turbulence, vulnerability, and concern about financial viability.

As a response to this trend, healthcare providers are being pressured to do more with less and to achieve better outcomes in the process (Berwick, Godfrey & Roessner, 1991). To this end, quality assurance has been replaced by quality improvement, continuous quality improvement, total quality management and statistical measurement of patient clinical outcomes (Marszalek-Gaucher & Coffey, 1991). Another result of this trend is that healthcare providers, like other types of organizations, are controlling costs by moving from full-time employment to outsourcing, contacting, and buying services on an as needed basis (Health Advisory Board, 1989).

A second trend affecting healthcare is mergers and alliances. Hospitals are increasingly recognizing the need to align and become part of a healthcare system (Health Care Advisory Board, 1994). Similarly, physicians who used to practice independently, today practice collaboratively. Physicians are increasingly becoming hospital employees, joint venturing with hospitals in shared ownership/risk opportunities or forming networks to contract for patients on a capitated basis. A result of this trend is that the field is moving from one comprised mostly of individual, fragmented providers to one increasingly comprised of fully-integrated healthcare delivery systems.

The third trend is the changing view of consumers. In the past, healthcare providers viewed individual patients both as primary customers and as uninformed individuals who

passively needed medical treatment--the more medical treatment, the better. Today providers increasingly recognize healthcare purchasers and their employees as major customers with each individual patient viewed as an integral part of his or her healthcare team. Patients are participating more in the decision-making and the care process and are being required to pay more out-of-pocket expenses.

A result of this trend is that healthcare providers are seeking ways to simultaneously meet the needs of individual patients and the needs of healthcare purchasers and their employees. So they are pursuing strategies that allow healthcare to be provided to more consumers at lower expense. These strategies are designed to increase the patients' ownership of their problems and satisfaction with care and, at the same time, decrease costs, administrative inefficiencies, and unnecessary services.

Each trend described above exerts a powerful force on healthcare providers, and when integrated the trends cause a fundamental reshaping of the field. The Health Care Advisory Board (1992, 1994) recently described the reshaping of one type of provider, hospitals. They pointed out that the hospital of old is being totally and radically restructured to provide more effective, efficient patient-centered care. The dynamic business environment and the restructuring of healthcare entities by their very nature alter the roles of key stakeholders including nurses, physicians, and allied health professionals.

One strategy that providers are using to adapt to the changing business environment is multiskilling. The expectations are that this strategy can lower costs, facilitate collaboration among those providing care, and increase patient satisfaction.

Perspectives from the Multiskilling Literature

Multiskilling is a form of working that seeks to promote the exchange, sharing and common ownership of tasks. Zander (1992) described multiskilling as an approach that is designed to eliminate multiple caregivers, improve continuity and resource utilization, and broaden jobs. The outputs of multiskilling include the re-arrangement of existing day-to-day work and the creation of teams to undertake short-term and long-term improvement projects (Bureau of Health Professions, 1994).

A clearer definition of this term is provided by the National Multiskilled Health Practitioner Clearinghouse (Bamberg, Blayney, Vaughn & Wilson, 1989) who delimit the multiskilled health care practitioner as follows:

> A person who is cross-trained to provide more than one function, often in more than one discipline. These combined functions can be found in a broad spectrum of health related jobs ranking in complexity from non-professional to professional level including both clinical and management functions. The additional function added to the original healthcare worker's job may be of higher, lower, or parallel level. (p. 14)

A concept related to multiskilling is patient-focused care. Patient-focused care appears to have its origins in projects initiated by the healthcare consulting industry in the mid- 1980s. The most prominent information published on consulting firm projects centers on the work of Booz-Allen Health Care Inc. The Booz-Allen concept of patient-focused care evolved from a three-year review of twelve institutions (Lathrop, 1991, 1992). The study's findings revealed that the amount of compartmentalization in modem hospitals is the primary contributor to poor service and high cost.

Patient-focused care was a specific model for institutional change started by staff and consultants at Lakeland Regional Medical Center in Lakeland, Florida with consulting help from Booz-Allen. Patient focused care involved grouping patients based on the resources that were needed, and redeploying services and staff to patient care units where through extensive cross-training and team assignments, 80% of all care needed by the patient could be provided on the unit (Makely, 1994).

According to Lathrop (1991), the objectives of patient focused care are:

1. reduction in time spent in scheduling, transportation, documentation, and structural idle time and devotion of much of the time saved to direct patient care;

2. elimination of some staff time, reducing cost per patient day;

3. improvement in patient perceptions of quality and level of caring; and

4. improvement in staff members' satisfaction with their roles, which would improve retention and reduce turnover.

Commonalties between the concepts of multiskilling and patient-focused care are the use of generalists and teams and the expected approach that employees have toward working. Employees have the freedom to progress tasks as far as they can, either as individuals or as members of a team. They are expected to seek help and assistance from colleagues and to be able to judge for themselves how far they can competently progress work. Multiskilling does not mean that employees become jacks-of-all-trades and masters of none. What it does mean is that employees are expected to take an adult, open-minded approach to their work both in their primary skill area and in other areas. The development of multiskilling is usually based on two principles (Bureau of Health Professions, 1994): (a) competency within the

workplace where employees assess and rectify problems as they occur day to day, (b) the full utilization of capabilities.

Multiskilling offers a new framework for considering who does what and how it gets done, what specific skills are required to perform which tasks, and when and how employees can acquire skills. The benefits of multiskilling for the provider can be expected in areas such as increased productivity, reduced management hierarchies, better use of resources, and improved customer service. As Cross (1991) pointed out, such benefits are very appealing to a healthcare industry that is facing significant economic challenges.

Multiskilling also benefits health care professionals. Healthcare roles and responsibilities are evolving and are impacting traditional health occupations significantly. Shortages of hospital workers are being replaced by surpluses, and jobs in hospitals are decreasing whereas out-patient jobs are on the rise (Makely, 1994). With the healthcare world needing fewer specialists and more generalists, traditional, profession-centered roles are being redesigned into patient-centered roles. In this environment, multiskilling provides a strategy for individual employees who want to learn additional skills and remain employable.

The ramifications of multiskilling for healthcare professions, their roles within the healthcare systems of the future, and the educational reform required to produce the healthcare worker of tomorrow are immense. Previously well-defined roles are now blurred. For example, the nurse's role in many organizations has changed to one of working on patient care units, alongside a broad range of ancillary staff and supervising assistive, non-nursing personnel. No longer does the head nurse alone run a hospital nursing unit, delegating tasks to other nursing personnel. Instead, non-nurses frequently manage these

units. And, the days of ample staffing have given way to limited support staff and a do-it-yourself attitude.

In this environment, professional scope of practice, which once regulated employers, is now stretched to its legal limits and sometimes beyond. Increasingly, petitions to implement waivers to current law are being made. Policy makers are resisting laws that restrict professional practice; they are tending towards reducing regulations, and are revisiting existing policy to identify and remove unnecessary barriers (Makely, 1994). The power of the professional association has been replaced by the power of the major purchasers of healthcare. Whereas in the past professional associations were viewed as watch dogs for quality, today they are viewed as turf-protectors (Pew Health Professions Commission, 1994).

In summary, multiskilling serves as a useful strategy for healthcare providers who are adapting to the trends that are reshaping the field. However, implementing this strategy has implications for healthcare providers, employees, and health care educators. The next section of the paper details the implementation of multiskilling and patient-focused care by one organization and describes the specific issues faced by each stakeholder group.

Multiskilling in One Organization: A Case Study

In 1990, Hillcrest Medical Center, a 607 bed facility in Tulsa, Oklahoma initiated a project to implement patient-focused care that had multiskilling as its core. Hillcrest management recognized the implications of the trends impacting the healthcare field and proactively decided to initiate this project to improve stakeholder satisfaction and lower costs

Prior to its implementation, Hillcrest's President and Chief Executive Officer (CEO) wrote a Message from the President that provided the following contextual frame for the project:

> Over the years, hospitals have been places where doctors, nurses and other skilled professionals come together to care for sick and injured patients. In more recent times, however, the proliferation of modem technology, together with professional specialization have combined to create a hospital environment where more and more care givers know more and more about less and less. . . .We should not be surprised to learn that the specialization, compartmentalization and fragmentation of everyday hospital tasks actually get in the way of smooth running, cost effective operations. . . (Skill, 1991, p. 1)

Because the project represented significant change in organizational procedure and would require carefully planned implementation, Hillcrest decision makers engaged external consultants to guide the initial data gathering and project implementation. Each step in the planning and implementation process is described in the following paragraphs.

Step one involved forming a team whose task was reviewing the way we do things today and offering recommendations. Team members, who served voluntarily, were selected based on their diverse clinical expertise. The team was comprised of nine members--Hillcrest employees at all levels of the organization. In addition, the consulting group worked closely with this team.

Step two involved assessing current performance. To accomplish the task of reviewing the way we do things today, the team divided into three subgroups, each focusing on one of the following areas: examination of the professional and clinical staffs, analysis of the administrative and business functions, and stud y of the support functions.

Accomplishing this step was not easy. It required the cooperation of team members from different hospital areas, different cultures, and different problem solving skills and life experiences. As members of the subgroups scrutinized their own and other areas in the hospital, they often engaged in self-examination and rigorous debate among themselves. As Still (1991) reported in the hospital's magazine, accomplishing the task also involved

> shedding of professional skins that are acquired with great cost over time. It also asked of all of us that we leave departmental boundaries and turfs that we had enormous stake in building. . We stopped seeing the world with *pharmacy glasses, accounting spectacles, or nursing bifocals.* We started seeing ourselves as our patients see us—a kaleidoscope of faces often asking the same question they answered an hour ago, systems that cannot produce snacks without notice, and a bewildering barrage of titles who appear too busy to ask a question. (p. 3)

In analyzing the data, the team discovered that only small percentages of staff time were given to direct patient care activities, such as giving medications, changing dressings, taking temperatures or assisting with surgery or procedures. In contrast, the majority of staff time was dedicated to scheduling, transportation of patients or goods and documentation of care. In addition, approximately one-fifth of staff time was structural idle time--time that staff members with narrowly assigned tasks spent waiting for the opportunity or need to carry out those tasks.

Step three involved developing recommendations. The consultants favored implementing a patient-focused model that they had used in other locations. Members of the project team felt that this model was inappropriate in its entirety for the organization's culture, system,

and politics. Instead, the project team favored developing prototypes. Developing prototypes would limit the amount of change that had to be absorbed in one time. It would also allow the opportunity to have support systems in place to modify and refine the designs as Hillcrest stakeholders realized how the project worked.

Using an external facilitator, the team members met, processed the situation, and developed recommendations for management. The team recommended implementing two pilot prototypes, one on a general medical surgical unit and the second on a cardiac unit. They further recommended that the majority of patient care on the prototypes be provided on the unit. Strategies for accomplishing this goal included grouping patients based on resources needed, redeploying services, and providing staff with multiskilling. With multiskilling, the expectation was that a patient's care could be provided consistently by a small number of workers who would became familiar to the patient. The team also recommended using solely internal resources to implement the project. The CEO and the members of the executive staff accepted the recommendation.

Step four involved implementing the pilot projects. Employees volunteered to participate in the multiskilling and to work in decentralized, patient-units. The expectation was that unit based staff would work together to accomplish the following tasks for the unit: admit patients, code medical records, change linen, distribute meal trays, perform phlebotomies and provide basic care, routine lab tests and routine respiratory care. The team conducted a needs assessment to determine the specific skill sets of the caregivers and the clinical demands of their patient populations. The team used Hillcrest training and development staff expertise in designing and delivering customized training that matched the needs.

Step five involved evaluating the project results. The success of the project was assessed using measures of patient satisfaction, physician satisfaction, employee job satisfaction, and sound financial performance. Surveys were used to gather the satisfaction data. The results of the surveys indicated that each stakeholder group's satisfaction was higher with patient-focused care and multiskilling. Multiskilled staff capably demonstrated their new abilities, and both patients and physicians appreciated the personalized nature of patient care. Patient and physician surveys showed perceptions regarding quality of care to be higher. Staff reported higher levels of job satisfaction attributed to an increased sense of competence, increased skill sets and closer interaction with the patients.

In evaluating financial performance, it was discovered that the two pilot projects did not generate the cost savings expected if implementation had been considered on a broader scale. The difficulty in measuring the financial benefits was that after the project was implemented the hospital operated with two systems: the prototype units operated using a patient-focused system and multiskilling and the other units operated using a functional system. The use of two systems meant that even when employees on the prototype units provided services, the hospital still needed to maintain central services to meet the needs of units operating under the functional system.

Analysis over time revealed that implementing multiskilling had low costs and high benefits. Implementing patient-focused care, on the other hand, required extensive capital start-up costs. Today, the prototype units are still in operation at Hillcrest HealthCare System, multiskilling training is still being used, and under the leadership of the president

and CEO the organization continues to explore ways to maximize human performance and leaning in healthcare.

Hillcrest Healthcare System has profited from the many lessons learned during the implementation of this project. One lesson was that multiskilling and patient-focused care did result in better patient care. Another lesson was the importance of needs assessment. In implementing human resource performance improvement, Sleezer (1991) advocated analyzing organizational needs, work-behavior needs and individual capabilities. In implementing the project at Hillcrest, each of these levels of analysis was critical to the project's success. Yet, another lesson learned was the importance of adapting this process of organizational change to fit the organization's culture, system, and politics. Hillcrest leaders continue to view multiskilling as a key strategy for addressing healthcare challenges. An important contribution to this view was the involvement of Hillcrest staff in designing and implementing the project.

Conclusions

Multiskilling can provide benefits to healthcare providers, healthcare professionals and patients. But, implementing this strategy means breaking new ground for both employers and educators. It requires rethinking boundaries, gaining broader perspectives, and valuing generalist skills. Multiskilled education and training is similar to other programs in that it poses its own challenges and controversies. One challenge is that there are no universal essentials or guidelines available to guide practitioners and educators.

Another challenge is identifying who will train multiskilled workers, To be effective, multiskilling education or training must be relevant to the employees' jobs and organizational

business goals. Colleges, universities and schools of allied health educated health professionals very capably in the 1980s. In the 1990s, health providers are increasingly willing to education and train staff when schools are unable or unwilling to do so--but such training comes with a high price tag.

As recently as ten years ago, health professional associations and schools that responded promptly to health sector changes could be seen as being in control, if not in command of their environments. Today the strategy of merely reacting to change in one's environment is a sure sign of professional rigor mortis. As Selker and Broski (1991) point out, the future increasingly belongs to those who are anticipating, shaping and influencing change even as they are immersed in it. Multiskilling provides a way to harness the future.

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