

'Planning a National Nursing Quality and Safety Alliance' Environmental Scan and SWOT Matrix

Background

The 'quality enterprise' has been defined as the building blocks that enable the delivery and improvement of evidence-based care.¹ This enterprise is dependent on a series of inter-related building blocks and investments that include:

- national quality improvement goals and priorities;
- standard and consensually developed performance measures that enable evaluation of progress against the goals and priorities;
- public reporting of health care performance to motivate improvements, hold providers accountable, and drive consumer and purchaser selection;
- translational evidence-based practice to stimulate rapid improvement; and
- value-based purchasing programs that align payment with performance and incentivize stakeholders to achieve higher levels of value.

It is within this context that the role and function of a nursing quality alliance has been contemplated (see complementary document Item G, *Developing NQSA: Mission, Purpose, and Priorities*). This environmental scan and Strengths-Weaknesses-Opportunities-Threats (SWOT) Matrix assumes that the proposed mission of a dedicated nursing quality alliance is to "achieve high quality and safe patient-centered care by contributing nursing knowledge, expertise, and discovery to the quality enterprise."

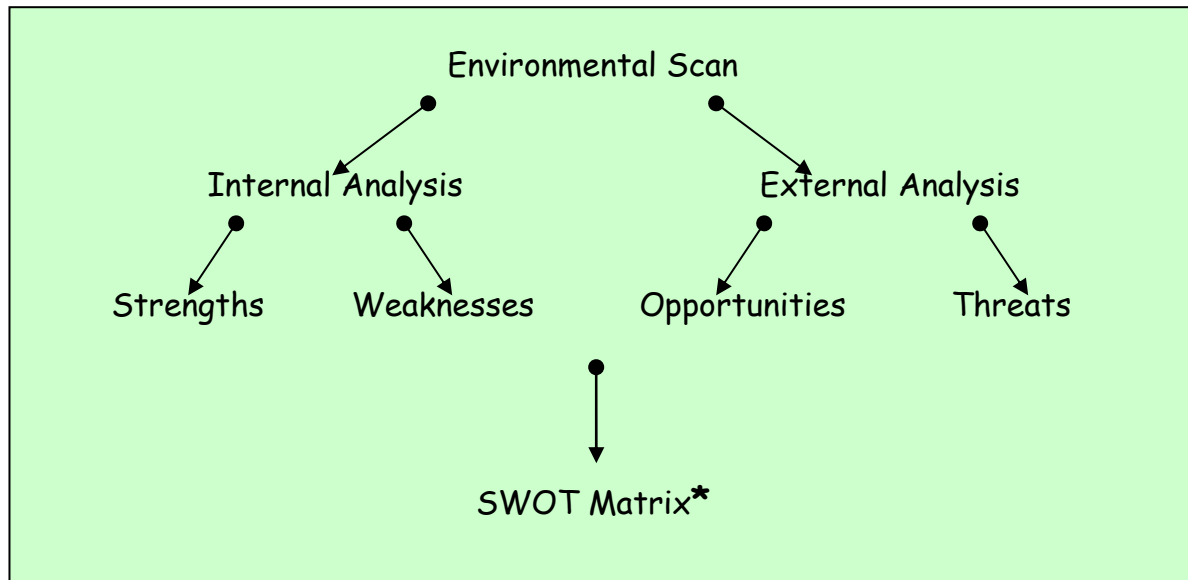
In developing a SWOT analysis for the Nursing Quality and Safety Alliance, three primary purposes emerge as key opportunities:

1. inspiring continued trust and confidence among the public in the nursing profession;
2. leveraging the single largest health care workforce in accelerating performance improvement and the national policies that underpin quality; and
3. driving policies that accelerate nursing-directed improvements in quality and safety.

Typically, a SWOT analysis focuses on internal strengths and weaknesses and external opportunities and threats. In this instance, these concepts have been applied to a proposed alliance that serves these three proposed purposes.

¹ The Strategic Framework Board's Design for a National Quality Measurement and Reporting System. *Med Care*. 2003;41(1) Supplement:I-87-I-89, January 2003.

Figure 1. SWOT Analysis Framework



Typically, SWOT analyses are presented in tabular formats and entries are listed in one of four quadrants in the table (i.e., strengths, weaknesses, opportunities, threats). While the SWOT analysis is presented in table 1, a second analysis – referred to as a SWOT matrix – has also been prepared (table 2). The matrix is a less familiar tool and, unlike the SWOT table, generates a potential strategic direction. Simply put, the SWOT matrix helps portray combinations of the seemingly unrelated items within the SWOT table to enable action.

Table 1: SWOT

<u>Strengths</u>	<u>Weaknesses</u>
<p>1. Inspire continued trust and confidence</p> <ul style="list-style-type: none"> a. Existing national and regional databases portraying nursing care quality (e.g., NDNQI system) and “lessons learned” b. Competing/similarly nursing focused/dedicated organizations to proposed NQSA do not exist c. Existing nursing research organizations (e.g., NINR) and expanding funds for nursing research under stimulus bill d. Continuing high level of trust of the American public (Gallup Polls) e. Expanding success (e.g., number of hospitals, evidence-based link to quality/safety) of the Magnet program f. Existing nurse workforce as the largest segment of the health care workforce g. Expanding and maturing evidence-base that establishes nursing-quality-value linkages h. Participation from and engagement of 8 major nursing organizations (70 others informed) in NQSA planning grant i. Continuing interest in advancing patient-centered care--willing to ask, “What is best for the patient?” j. Existing, substantial investments in the areas of education, competency development, and leadership by convener organizations k. Nursing’s historic position championing diversity (ethnicity, culture, gender, religion, SES) and its implications for health care and the health care workforce <p>2. Accelerate performance improvement</p> <ul style="list-style-type: none"> a. Expanding and maturing evidence-base that establishes nursing-quality-value linkages b. Availability of NQF15 and select measures that cross settings of care (e.g., wound/pressure ulcer measure in hospital, nursing home, and home health settings) c. HQA’s recent approval of all NQF-endorsed nursing sensitive measures d. Existing national, regional, and state nursing performance measures databases (e.g., NDNQI, CalNOC, Maine and Massachusetts) e. Existing national quality measurement and reporting infrastructure (e.g., Compare websites) f. Experience with, and advancement of, measure development and data collection (i.e. NDNQI, AWHONN EDGE™ Database, etc) g. Presence and expansion of nursing-sensitive measures in public reports of performance (e.g., Consumer 	<p>1. Inspire continued trust and confidence</p> <ul style="list-style-type: none"> a. Existing manual and electronic systems limit what data we have (e.g., robust acuity systems) b. Existing, numerous professional nursing organizations and specialty groups result in fragmentation and diffusion of the expertise and resources among nursing as a whole c. Creating a new “fancy” Alliance may not change nursing’s image from that of a profession that “takes orders.” We may remain unable to gain access to high levels of policy making and policy makers d. Funding source for sustained support is unknown e. Nursing participation would be voluntary (e.g., What incentive would organizations have to provide technical time and support for NQSA?) f. Nursing lacks experience in constructing or operating a national alliance <p>2. Accelerate performance improvement</p> <ul style="list-style-type: none"> a. Resources are inadequate to support the demands of data collection protocols (e.g. trauma registry data in 4 databases is symptomatic of this problem). b. Representation of VANOD, CalNOC, MilNOD is lacking in the convener group gathering under the planning grant c. Lacking sufficient nursing-sensitive outcome measures and resulting data to address all patients in all settings across an episode of care d. Isolation of each profession having its own quality alliance: Are we balkanizing performance measurement and thus patient care? e. Development of standard language may be necessary prior to creating standard measures (e.g., birth date or date of birth) f. Nursing has no control of medical record for something similar to an E-Code g. Multiple locations currently house nursing data

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<p>Assessment of Healthcare Providers and Systems [HCAHPS], Hospital Compare)</p> <p>h. Emergence of recent national quality improvement goals via the National Priorities Partnership</p> <p>3. Drive policies that accelerate nursing-directed improvement</p> <ul style="list-style-type: none"> a. Existing nurse leaders with strong organizational skills and credible backgrounds b. Existing evidence suggests that hospital nurses recognize opportunities to strengthen their policy voice c. Evidence also suggests that nurses make effective policy advocates 	<p>3. Drive policies that accelerate nursing-directed improvement</p> <ul style="list-style-type: none"> a. Nursing is not typically a ‘target’ of federal policies because of employee- employer relationship (rather than direct contractors with payers for services) b. Nursing organizations approach policy makers with multiple requests: lack of unity c. Nursing inclusion within existing Alliances may be viewed as duplicative d. Insufficient positioning of nursing performance among policy maker’s source materials (e.g., need to penetrate <i>NEJM</i>, <i>JAMA</i> and <i>Health Affairs</i> to reach policy makers) e. Data collection, reporting and timing are not yet geared to meet policy makers’ needs and interests f. Nurses and nurse professional organizations have historically lacked consistent messages or a cohesive approach to policymakers and regulators (as per J. Miller MPH, RN of CMS) g. Nursing workforce is not engaged in the political process and impaired from doing so by powerful barriers (e.g. lack of time, inadequate socialization to the process, lack of “relevance”)
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Opportunities

1. Inspire continued trust and confidence

- a. Identify (empirically, anecdotally) the value-added of nursing
- b. Improve consumer information about the quality of nursing care
- c. Reward nurses and institutions for excellent performance
- d. Explore the Hospital Compare website as a competitive tool for institutions to provide information about outstanding nurse performance
- e. Explore alignments with Center to Champion Nursing (AARP and RWJF)
- f. Explore partnering with nursing unions
- g. Strengthen nurse-led recognition programs by providing comparative effectiveness data (e.g. nursing has received much)

2. Accelerate performance improvement

- a. Link with INQRI (Nursing Quality Research Initiative) to translate research into measurement that can improve practice
- b. Continue quid pro quo to various Alliances (i.e. HQA, KCA, QASC) providing entry into these policy discussions
- c. NQSA can serve as a neutral reporting entity to achieve economies of scale and scope by moving performance measurement reporting from various nursing organizations to a central source.
- d. Advocate for standard measures, definition and standard analytic protocols to allow for “apples to apples” comparisons:
NDNQI (National Database of Nursing Quality Indicators)
VANOD (Veteran’s Affairs Nursing Outcomes Database)
CalNOC (California Nursing Outcomes Coalition)
MilNOD (Military Nursing Outcomes Database)
AWHONN EDGE Database™
- e. Sequencing of measurement development: begin with hospital measures followed by hospice, school nursing, home health
- f. NQSA sets agenda for measure adoption and collection
- g. Influence national surveys that address health care quality to gather information relative to nursing practice (e.g., National Ambulatory Medical Care Survey)
- h. Learn from the NSPC (Nursing-Sensitive Patient-Centered) and NSSC (Nursing Sensitive System-

Threats

1. Inspire continued trust and confidence

- a. Variability in mission and values of each convener/ nursing organization
- b. Data may portray low quality nursing performance with subsequent unintended consequences for nursing

2. Accelerate performance improvement

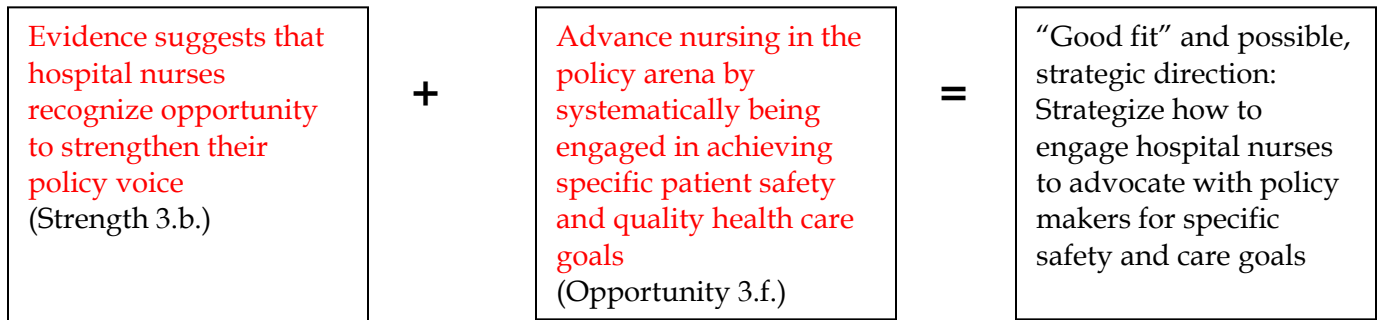
- a. Current national practice specialty organizations (AORN, AANA, ONS, AWOHNN, AACN, ACNM) have limited resources and will have to decide where to invest (e.g., choices will need to be made that could result in weakening NQSA)
- b. Established boards of large nursing organizations may refuse to support or may change support as leadership and resources fluctuate
- c. Potential that naming the group an “Alliance” may result in the perception that it is limited to the focus on performance measurement
- d. Existing support from CMS’ leadership regarding the development of a nursing alliance is questionable
- e. Alliances with whom nursing has a quid pro quo relationships have not universally welcomed nursing participation and have rationed our involvement (e.g., don’t recognize different nursing groups)

<p>Centered) Health care Quality Data Sets public reporting in Maine</p> <ul style="list-style-type: none"> i. Learn from Patient First initiative in Massachusetts j. Create structure and processes for development, adoption, dissemination of nursing goals k. Link nursing performance with costs and cost savings l. Build relationships with Centers of Excellence m. Partner with the Hospital Compare and Quality Check n. Establish nursing as a full partner in the RHQDAPU (Reporting Hospital Quality Data for Annual Payment) p. Improve public reporting of nursing-sensitive outcomes q. Potential for nursing performance measures to lead to pay-for- performance for nurses (for good or bad) <p>3. Drive policies that accelerate nursing-directed improvement</p> <ul style="list-style-type: none"> a. Vision for proactive, forward thinking policy agenda that can Push (e.g. What do <u>we want</u> decision makers know about nursing performance?), Pull (e.g., What do decision makers <u>already know</u> about nursing performance?) and/or Partner (e.g., What do decision makers want/need to know about nursing performance?) b. Federal Health Board may be supportive (but is a threat if non-supportive) c. TJC has completed validity and feasibility testing of the NQF standards for nursing-sensitive care and NQF's maintenance of them enabling enable more rapid and uniform adoption by hospitals d. NQF endorsement of national voluntary consensus standards for nursing-sensitive care signals the importance of nursing's contribution to inpatient care quality e. Laws requiring transparency including cost, prices, and quality may initiate a demand for nurse performance information (required in Florida, Delaware, Georgia, Minnesota, New Mexico, Vermont, Wisconsin) f. Advance nursing in the policy arena by systematically being engaged in achieving specific patient safety and quality health care goals g. Work with consumer and purchaser groups (e.g., Consumer-Purchaser Disclosure Project) h. Work with employers and business coalitions (e.g., U.S. Chamber of Commerce) i. Build upon new economic stimulus funding (e.g., get in on ground floor of electronic data system building in healthcare) j. Ability to build/expand capacity by preparing a new group of nurses to assume leadership in this area k. Synergies from nursing organizations to align support for a more powerful unified nursing organization 	<p>3. Drive policies that accelerate nursing-directed improvement</p> <ul style="list-style-type: none"> a. Absence of nursing voice/ role in Obama White House b. Absence of large pool of informed nurses for roles in policy setting related to quality/safety c. Potential for a Federal Health Board to be non-supportive d. Absence and inattention to nursing issues/strengths in health care reform proposals e. Presence of a strong medical lobby f. Potential for the formation of NSQA to be viewed as an attempt to mandate staffing levels or remove mandatory overtime (i.e., platform for nurses to collect data to "make a point") g. Established alliance landscape and inconsistent/ 'unwelcoming' nature among existing alliances to nursing h. Potential for nurses to lose their seats on existing Alliances with the start-up of a NQSA i. Lack of awareness by policymakers of the necessity to engage nursing to realize dramatic and sustainable improvements in quality and safety
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Table 2: SWOT Matrix

	STRENGTHS	WEAKNESSES
OPPORTUNITIES	<u>S-O Strategies</u> : Pursue opportunities that are a good fit to our strengths	<u>W-O Strategies</u> : Overcome weaknesses to pursue opportunities
THREATS	<u>S-T Strategies</u> : identify ways to exploit strengths and to reduce vulnerability to external threats	<u>W-T Strategies</u> : establish a defensive plan to prevent weaknesses from limiting success and causing susceptibility to outside threats

Example: From Goal 3. Drive policies that accelerate nursing-directed improvement



Key Questions

In its review and deliberation, the group may wish to consider the following key:

1. *What general reactions does the group have to the SWOT analysis?*
2. *What specific additions, revisions, and enhancements are suggested?*
3. *Based on the analysis, what specific action steps should be pursued to best position the developing Alliance?*

Next Steps

In order to finalize the SWOT analysis and derive subsequent activities that might be meaningfully pursued via the matrix, the following steps are recommended:

- Project staff will revise the SWOT analysis based on the convener group’s reactions, suggestions, revisions, etc. Ultimately, the final SWOT will serve as both a tool for future planning (e.g., soliciting funding for any launch of NQSA activities) and a deliverable to the Robert Wood Johnson Foundation (RWJF).

- As illustrated by the example above, develop SWOT matrix items to assist in prioritizing strategic directions. To accomplish this:
 - Project staff will solicit from each convener representative up to two items from each cell of the SWOT (i.e., 2 items from each quadrant – strengths, weaknesses, opportunities, threats) as the highest priority for further analysis; and
 - Project Staff will apply the matrix tool to synthesize and identify possible strategic directions;
- The conveners will review the final SWOT analysis and matrix during the April 8th in-person meeting.