



**'Planning a National Nursing Quality and Safety Alliance'
The Promise of Patient Partnerships**

Background

Over the last several months, leaders from several of the nation's nursing organizations have been convening to discuss a shared interest in improving health care safety and quality. Referred to as the Nursing Quality and Safety Alliance¹, this collaborative is based on the following assumptions:

- **Despite the significant investments and ongoing contributions by diverse constituencies, continued and significant lapses in patient safety and health care quality exist.** Today's system is plagued by suboptimal, uneven, and error-prone care. While early reports published by the Institute of Medicine^{2,3} placed a spotlight on health care quality, more recent reports^{4,5,6,7} have generated new knowledge in this area and confirmed what we have suspected for years – that tremendous dysfunction, chaos, and under performance exist in every setting of health care and for all patients.
- **In addition to low-level performance, disparities and inequities persist.** Based on findings from the Agency for Healthcare Research and Quality's (AHRQ) 2007 National Healthcare Disparities Report⁸, persistent inequities exist. The report notes that, "disparities in quality and access for minority groups and poor populations have not been reduced since the first NHDR."
- **Patient perception of nursing care is relatively low.** Based on responses to the CAHPS® Hospital Survey, there is significant opportunity to improve patients' perceptions of care that is directly influenced by nurses. For example, more than 25% of patients who had overnight hospital stays from July 2007 through June 2008 and who responded to the

¹ The term Nursing Quality and Safety Alliance is being used to refer to the collaborative alliance envisioned in this paper although, at this time, is not intended to be a formal name/title.

² Institute of Medicine (IOM). *To Err is Human: Building a Safer Health System*. Washington, DC: National Academies Press. 2001.

³ Institute of Medicine (IOM). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press. 2001.

⁴ Agency for Healthcare Research and Quality. *2007 National Healthcare Quality Report*. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality; February 2008. AHRQ Pub. No. 08-0040.

⁵ Agency for Healthcare Research and Quality. *2007 National Healthcare Disparities Report*. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, February 2008. AHRQ Pub. No. No. 08-0041.

⁶ The Joint Commission. *Improving America's Hospitals*. 2008. Oakbrook Terrace, IL: The Joint Commission, November 2008.

⁷ The Commonwealth Fund. *Why Not Be the Best? Results from a National Scorecard on U.S. Health System Performance, 2008*. New York, NY: The Commonwealth Fund; July 2008.

⁸ Agency for Healthcare Research and Quality. *2007 National Healthcare Disparities Report*. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, February 2008. AHRQ Pub. No. No. 08-0041.

survey indicated that nurses did not always communicate well. This is particularly significant compared to patients' higher rating of doctor communication (i.e., 20% of patients indicated that doctors did not always communicate well). Other notable CAHPS Hospital Survey indicators, which nurses influence include: 38% of patients who reported that they didn't always receive help as soon as they wanted it, 32% who reported that their pain was not always well controlled, and 41% who reported that staff did not always explain their medicines in advance of administering them.⁹ Because no standardized patient perception survey exists for other settings of care (e.g., home health care or outpatient surgical settings), readily accessible data are not available.

- **Limited information exists on which to quantify nursing's contribution to value.** Value and efficiency are terms that typically refer to the cost of care or resource utilization to a specified level of quality of care.¹⁰ Along with patient-centeredness, safety, effectiveness, timeliness, equitable, efficiency is viewed as a fundamental aim of the health care system.¹¹ Yet despite significant efforts to improve cost transparency by the Centers for Medicare & Medicaid Services (CMS)¹² and other payers – largely focused on providers and physicians – standard metrics that inform clinicians, providers, payers, and the public about price, efficiency, and value are difficult to calculate and challenging to publicly report.¹³ The nurse-value connection has been relatively uncharted.
- **Nurses are not routinely 'tapped' in policy setting despite a unique expertise, knowledge, and skill set.** Invitations to serve on national committees, advisory boards, technical panels and in other consultative roles are limited and frequently offered to non-nurse health professionals. Especially among those organizations that directly inform policy (e.g., Institute of Medicine, Medicare Payment Advisory Commission, National Quality Forum), appointments of nurses are often overlooked. Notwithstanding the significant investments by the existing nursing organizations, there are many instances of policy making that have not fully benefited from nursing's knowledge or expertise.
- **Without significant improvements to the environment including, but not limited to the nursing work environment, rapid and sustainable improvements in health care performance and value are unlikely to be fully attained.** A strong, compelling case has been articulated by independent organizations, advisory boards, quasi-governmental bodies, and government agencies for needed changes in the management, workforce

⁹ Available at <http://www.hospitalcompare.hhs.gov>. Last accessed March 25, 2009.

¹⁰ National Quality Forum (NQF). *Measurement Framework: Evaluating Efficiency Across Episodes of Care*. Washington, DC: NQF. November 2007. Available at <http://www.qualityforum.org/pdf/projects/priorities/NQFFramework%20COMMENT%2006Nov07.pdf>. Last accessed November 21, 2008.

¹¹ Institute of Medicine (IOM). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press. 2001.

¹² Executive Order 13410 - Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs. August 22nd, 2006.

¹³ *Health Care Efficiency Measures: Identification, Categorization, and Evaluation*. AHRQ Publication No. 08-0030, April 2008, Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/qual/efficiency/>.

deployment, work design, and organizational culture of nurses to mitigate threats to health care safety.¹⁴

In short, Americans continue to receive care that falls below that which is deserved. Immediate action by nurses is, at least in part, a potential solution.

Making the Case for Action

Ongoing lapses in quality and safety, escalating health care costs, and expanding numbers of uninsured have created unsustainable political tensions. The promise of health care reform under the new Administration has readied policy makers, consumers, patients, employers, providers, practitioners, and other stakeholders for change.

Despite likely political momentum, four colliding forces negatively impact how nursing is perceived and engaged in these directions:

- force of **invisibility** of nurses among consumers, patients, and family members in quality improvement, safety, and error reporting and eradication;
- force of **indifference** among policymakers, public and private payers, health care executives, and the medical establishment regarding nurses' unique expertise, value, and ability to contribute to policy directions;
- force of **absence** of adequate and consistent research, performance measures, data collection and reporting of nursing care to quality adequately describe the footprint of professional nursing and quantify its value; and
- force of **fragmentation** among the professional nursing organizations resulting in unaligned and uncoordinated strategic professional efforts.

While invisibility, indifference, absence, and fragmentation may be formidable barriers, there are opposing forces that place nursing in a position of strength:

- Nursing is the single largest health profession in the United States.^{15,16,17} Over three million registered nurses (RNs) and licensed practical nurses (LPNs/LVNs) currently hold licenses. In size alone, nurses represent an 'army' of health care quality advocates;
- An expanding body of evidence links nursing's contribution to patient safety and health care outcomes.^{18,19,20} Results consistently demonstrate a nurse staffing-outcome effect for

¹⁴ Institute of Medicine. *Keeping patients safe: Transforming the work environment of nurses*. Washington, DC: National Academies Press, 2004.

¹⁵ Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook, 2006-07 Edition*, Registered Nurses, on the Internet at <http://www.bls.gov/oco/ocos083.htm> (visited July 06, 2007).

¹⁶ U.S. Department of Health and Human Services. *The Registered Nurse Population: Findings from the March 2004 National Sample Survey of Registered Nurses*. Washington, DC: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Nursing; February 22, 2002:6. Available at <ftp://ftp.hrsa.gov/bhpr/workforce/0306rnss.pdf>. Last accessed July 6, 2007.

¹⁷ U.S. Department of Health and Human Services. *Supply, Demand, and Use of Licensed Practical Nurses*. Washington, DC: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Office of Workforce Evaluation and Quality Assurance. Available at <ftp://ftp.hrsa.gov/bhpr/nationalcenter/lpn.pdf>. Last accessed July 6, 2007

failure-to-rescue rates, inpatient mortality, and length of stay. These effects are especially pronounced in surgical inpatients. These linkages suggest that nurses – in number, configuration, and practice – influence patient safety and health care performance.

- In public opinion polls, nurses are rated *the* most trusted and ethical professional. Over the last decade, nurses have consistently out rated physicians, managed care executives, clergy, college teachers, politicians, and public safety workers (e.g., law enforcement).²¹ Strengthening these natural tendencies will inspire continued trust and confidence among the public for nursing and health care.
- Shortages in the existing nursing and nurse faculty workforces, which are rapidly escalating, are widely recognized by policy makers and health care stakeholders. Estimates suggest that shortages in registered nurses alone are expected to reach 500,000 by 2025. According to recent reports,²² these shortages place quality issues in peril.
- Current national policy directions that accelerate performance measurement, public reporting, and value-based purchasing directly affect nurses but have not been informed, for the most part, by nurses.

In short, tremendous strength will be garnered by engaging and motivating nurses to influence national policy directions in these areas and contribute to improvements in patient safety and health care quality. The following briefly describes recent developments in the possible establishment of NQSA. Summaries from the individual conference calls and meetings, separately appended, provide greater detail.

Progress to Date

Early conversations among the national nursing organizations envisioned NQSA as a devoted, unifying “policy voice” for nursing that influences patient safety and quality directions in the United States. For example, initial discussions focused on proactively responding to current accountability and transparency policy directions promulgated by the Centers for Medicare & Medicaid Services (CMS) and serving as adviser and strategist in health care reform debates.

However, during its February 26, 2009 conference call, members of the national nursing organizations reconsidered this vision in the context of the changing environment, nursing’s ambitions, and its potential impact on the nation’s health. In their discussion, the group contemplated a transition from a “nurse-only” quality alliance – narrowly focused on strengthening professional nursing’s policy influence – to a “nurse-patient” quality alliance – broadly focused on advancing person-centered, high value nursing care in full partnership with consumers, patients, and their families. While this transition was introduced during its last

¹⁸ National Quality Forum (NQF). *National Voluntary Consensus Standards for Nursing-Sensitive Care: An Initial Performance Measure Set*. Washington, DC: NQF; 2004.

¹⁹ Needleman J, Buerhaus PI, Mattke S, Stewart M, Zelevinsky K. *Nurse Staffing and Patient Outcomes in Hospitals*. Boston, Mass: Health Resources Services Administration; 2001. HRSA Report No. 230-99-0021.

²⁰ Needleman J, Kurtzman ET, Kizer KW. Performance measurement of nursing care: state of the science and the current consensus. *Med Care Res Rev*. 2007 Apr; 64(2 Suppl):10S-43S.

²¹ The Gallup Poll®. Available at <http://www.gallup.com/poll/25888/Nurses-Top-List-Most-Honest-Ethical-Professions.aspx>. Last accessed January 22, 2008.

²² Buerhaus PI, Donelan K, Ulrich BT, Norman L, DesRoches C, Dittus R. Impact of the nurse shortage on hospital patient care: comparative perspectives. *Health Aff (Millwood)*. 2007 May-Jun;26(3):853-62.

discussion, the nursing conveners require more dedicated time to contemplate these possibilities. This paper explores the advantages of partnering with consumers, patients, and their families to improve nursing care quality in the United States and the extent that such a model counterbalances existing forces of invisibility, indifference, absence, and fragmentation.

The Promise of Patient Partnerships

Consumers are the ultimate beneficiaries of health care. Their dual roles as patient and purchaser were recognized under the Clinton Advisory Commission on Consumer Protection and Quality in the Health Care Industry,²³ which made several recommendations to strengthen the hand of consumers:

“Because consumers are the intended beneficiaries of health care, their needs should be of utmost importance. Economically, consumers are important because they expend the largest single amount of money for health care. Thus mobilizing the full power of the marketplace to improve health care quality requires that the power of the individual consumer be maximized. Stronger consumers also are better able to carry out their dual roles and responsibilities as purchaser and patient....” (page 115)

Over the last decade, inspired at least in part by the Commission’s report, consensus has been reached that activating and engaging consumers is an essential component to health care reform in the United States. Who better to advocate for expanded access, improved quality, and lower costs than patients themselves?

A strong rationale can be made for transitioning from a nurse-only to a nurse-patient quality alliance:

- On many issues (e.g., just culture, error reporting, self-care, patient education) patients and nurses share similar views and are “like minded.”
- Under a nurse-patient quality alliance, nurses, who have claimed to represent the patient ‘voice,’ will live up to this promise.
- Patients and nurses, each individually, make strong advocates; together, their combined effectiveness will likely be transformative.
- Involving patients as full partners in improving health care quality and safety is effective, authentic, and honorable.
- Beyond its honor, collaborating with patients is strategically persuasive.

A nurse-patient quality alliance builds on the natural tendencies of nurses and patients to independently serve as effective advocates, engage in collaborative decision making, and pursue truth and compassion. As envisioned, a nurse-patient quality alliance will create a more caring model of health care delivery.

While appealing and justifiable, partnering with patients significantly alters the alliance’s direction. Specifically, a nurse-patient quality alliance would shift its:

²³ President’s Advisory Commission Consumer Protection and Quality in the Health Care Industry. *Quality First: Better Health Care for All Americans*. Final report to the President of the United States. 1998.

- mission, purpose, and priorities;
- convening organizations and participants;
- configuration and governance system (e.g., board and leadership);
- organizing structures (e.g., committees, staffing);
- operating procedures (e.g., achieving consensus); and
- resource needs and financial requirements.

Table 1 portrays the major pros and cons of a nurse-patient quality alliance. A comprehensive Strengths-Weaknesses-Opportunities-Threats (SWOT) Analysis has been conducted (Item F), which fully describes the potential of this expanded model.

Table 1: Advantages of a Nurse-Patient Quality Alliance

| Pros | Cons |
|---|---|
| 1a. adds authenticity when speaking for/about patients | 1b. adds complexity to operational aspects such as leadership, governance, membership, dues, etc. |
| 2a. builds trust and confidence in the nursing profession among patients, families, the public, and other key stakeholders | 2b. distracts from internal, professional issues that deserve attention (e.g., work environment) |
| 3a. generates credibility among external stakeholders including policy makers | 3b. requires effort and resources to identify suitable and like-minded consumer, patient, family group partners |
| 4a. improves on models on which other quality alliances have formed which have not engaged consumers, patients, or their families | 4b. results in necessary conformance to shared/collaborative positions rather than nurse-only positions |
| 5a. represents a larger pool of stakeholders which strengthens its influence (and participating entities) | |
| 6a. concentrates nurses on their roles as healers in care rather than merely as advocates for their own profession | |
| 7a. dedicates significant, shared resources to improving quality, safety, and value | |

To assess its merits, the extent to which a nurse-patient quality alliance counterbalances the forces of invisibility, indifference, absence, and fragmentation that nursing faces can be explored:

This force is...
Invisibility



...addressed by the following pro.

- represents a larger pool of stakeholders which strengthens its influence (and participating entities) (5a)
- dedicates significant, shared resources to improving quality, safety, and value (7a)

Indifference



- adds authenticity when speaking for/about patients (1a)
- builds trust and confidence in the nursing profession among patients, families, the public, and other key stakeholders (2a)
- generates credibility among external stakeholders including policy makers (3a)

Absence



- builds trust and confidence in the nursing profession among patients, families, the public, and other key stakeholders (2a)
- generates credibility among external stakeholders including policy makers (3a)

Fragmentation



- improves on models on which other quality alliances have formed which have not engaged consumers, patients, or their families (4a)
- represents a larger pool of stakeholders which strengthens its influence (and participating entities) (5a)
- concentrates nurses on their roles as healers in care rather than merely as advocates for their own profession (6a)

In summary, enormous potential exists in broadening and reorienting the vision of an alliance to one that advances person-centered, high value nursing care in full partnership with consumers, patients, and their families.

Next Steps

This paper explores current, coexisting forces that might inspire and demand a new collaboration among the national nursing community in partnership with patients and the organizations that represent them (e.g., national patient safety groups). It substantiates a new and unique collaboration between professional nursing and the patients/families served. A corresponding SWOT analysis and matrix comprehensively detail the opportunities such an alliance presents.

Through a facilitated discussion, and with the advice and counsel of invited members of the consumer/patient community, the group will consider whether this shift in direction is supported and contemplate revised mission, purpose, and priority statements that reflect the establishment of such NPQA.