

Making Nurses Full Partners in Redesigning Health Care in North Carolina

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The Institute of Medicine of the National Academies recommends that nurses take a lead in reforming health care but recognizes significant barriers to nurses assuming such roles. In North Carolina, nurses must be on hospital boards, active in health policy debates, and empowered at the bedside and must lead financial decisions that improve care and keep hospitals financially viable.

The Institute of Medicine of the National Academies (IOM), in association with the Robert Wood Johnson Foundation, has made a recommendation about the future of health care, suggesting that nurses should be prepared and enabled “to lead change to advance health” [1p14]. The recommendation suggests that nurses have knowledge that health care organizations and policymakers need in order to make decisions that improve health care. For this recommendation to be implemented, North Carolina nurses and health care systems must overcome significant barriers. Nursing has a history of valuing subservience, order, and not questioning authority. As a result, nurses’ voices are often silent, when the insights they gain by close contact with patients could contribute to health care decisions. New reimbursement regulations require hospitals to provide quality care. Doing so will depend on nurses being empowered to share their knowledge.

Emerging From Subservience

Nursing is a “women’s profession,” with 93.4% of its workforce being female [2]. It is a profession that, historically, has taken “women and turned them into girls” [3]. Criteria used by early nursing schools to select students stressed traditional female behavior (eg, modesty), physical characteristics (eg, plain appearance), and subservience as desirable qualities. These traits brought to the nurse’s role all of the gender-specific characteristics of nonassertiveness—and their consequences. Add these qualities to the hierarchical society of the military and of religious orders, where nursing had its beginnings, and the stage was set for nurses to take orders, fail to question, and not offer their insights [3].

The reasons for nurses not taking on leadership roles are thus steeped in both gender and history and are hard to overcome. But today, it is recognized that the absence of nurses

from leadership positions poses a risk to patients and to the future of health care. Since the IOM’s disclosures in the early 2000s about injuries and deaths from unsafe hospital environments [4], no one can argue that health care does not need improvement. If nurses continue to subordinate their talents and insights and fail to help create solutions to these problems, it will only perpetuate the current, substandard level of care that is in desperate need of improvement.

Leadership and Decision Making

Legislature. Health policy in the state is established by the North Carolina legislature, which has benefited from the knowledge and experience of very few registered nurses. Until November 2010, North Carolina had elected only 1 registered nurse, Sammy Lee Beam, to its legislature. Beam was elected in 1982 and served for 2 terms in the North Carolina House of Representatives [5]. In 2010, Diane Parfitt, educated as a registered nurse, was elected to represent Fayetteville (House district 44). But at the same time, a retired registered nurse running in House district 103 was defeated when a group that did not want a registered nurse in the House infused \$75,000 into the campaign of the nurse’s opponent. The majority of other states have registered nurses in their legislatures. In 2007, there were only 11 states (including North Carolina) without a registered-nurse legislator, while some states had as many as 6 nurses serving in their legislatures (C. Mullinix, unpublished data).

The advantage of having nurses as legislators is that, when health care delivery and financial decisions are made, voices with intimate knowledge of direct patient care are present. For example, the 2011 North Carolina legislature is deciding whether in-home services for disabled adults should continue to be reimbursed by the state’s Medicaid program. A nurse’s knowledge of both in-home and institutional care could inform the discussion about the quality of life in these 2 settings, as well as discussions about the cost differences between them. Nurses could explain that

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institutionalization of an adult who is disabled costs North Carolina's Medicaid program almost twice as much as home care (\$1,400 vs \$750 per month) (Association for Home and Hospice Care of North Carolina, personal communication, June 3, 2011). Formal studies have confirmed the cost-efficiency of home care [6].

Hospital boards of directors. One consulting firm, advising hospitals on how to deal with the new reimbursement policy, states that the Centers for Medicare and Medicaid Services' "recent actions, assuming the new administration does not attempt to reverse the NCDs [national coverage determinants], gives a clear signal for other payers to use the Medicare NCDs and adverse conditions as a benchmark. This may create a national quality-of-care initiative that, if not responded to by providers, could prove disastrous for financial projections of patient revenue, undermine the credit ratings of hospitals, and establish a national standard of care that traditionally has been left to the local or state courts" [7].

In other words, currently for Medicare—and starting July 1, 2012, for Medicaid—reimbursement for patient care, which will eventually include private insurers, will be dependent on quality outcomes [8]. The costs associated with "never events," such as surgery on the wrong body part, and adverse events, such as hospital-acquired infections, will not be reimbursed [9]. The end result is that hospitals will need to work harder to prevent errors and ensure patient safety in order to be financially viable.

The key to making this happen lies in nursing care. Nurses are the major care providers who make the observations that can quantify the cost of patient care. Yet, many hospitals do not have nurses on their boards of directors, where these important decisions are made. In North Carolina, a survey of chief nursing officers revealed that, although some chief nursing officers attended board meetings, only 20% of hospital boards had decision-making positions filled by a nurse (C. Mullinix and D. Eslinger, unpublished data). This situation is similar to that in many other states [10] and means that knowledge of how best to prevent medical errors and translate these efforts into savings is absent for the majority of hospitals.

A North Carolina statute recognizes the value of nurses' knowledge [11]. The statute specifies that there must be a nurse (along with a physician and a dentist) on every county board of health, to advise health departments on policy. A survey of health policy leaders affirmed that nursing knowledge is also needed for health policy decision making in other settings, but such knowledge is rarely available or consulted because nurses are rarely at the table for such deliberations [10, 12]. The coming changes in funding for patient care effectively demand that this situation be changed.

Bedside. Nurses are often not empowered to provide the systemic solutions to improve patient care that are so needed by hospitals. Studies have documented the ways in which nurses repeatedly solve the same problems associated with care-related inefficiencies and potential harms to patients, resulting in discouragement among nurses, who nevertheless continue to try to provide quality care [13,

14]. The way nurses most often cope is via work-arounds, making do despite the lack of the kinds of resources they need—supplies, medications, and staff—to give the highest-quality patient care. One solution to this problem would be to systemically empower nurses to solve the problems they encounter every day, allowing them to be leaders at the bedside and capable of making necessary changes.

Ensuring the Financial Health of Hospitals

Nursing care is often not appropriately factored into financial decisions. Granted, there are few, if any, good measures of the resources needed to provide care. The commonly used metric of hours per patient day simply divides the total number of hours of care by the number of patients. It does not include a measure of acuity, increased work by nurses because of complex transitions in admissions and discharges, or the expertise of the care provider. Hospitals have refined their ability to calculate hours per patient-day by computerizing the variables and calculating the value for each shift. However, although hours per patient-day can be calculated with increased precision, this value gives little information about the quality of the care that is being provided. Yet, the changes in health care financing are being driven by such issues.

Nursing care is the key to improving the quality of health care and preventing adverse events. Important factors to consider are the number of additional nurses that are needed to prevent an adverse event and how the cost of an additional nurse compares with a forfeited reimbursement if an adverse event occurs. The exact amount that a hospital will *not* be reimbursed varies by hospital and cannot be estimated here. What is important is that, at this point, most hospitals have not considered it either. Most of them have not factored in this calculation as they prepare to adapt to the new rules for reimbursement. The challenge for hospitals' future financial health and viability is to learn how much and what kinds of additional nursing care can prevent errors. For instance, can 2 additional registered nurses—one for days and the other for nights—prevent the cases of ventilator-associated pneumonia for which the hospital will not be reimbursed?

Medicare and Medicaid are aware that, to get around the new rules, providers may try to hide adverse events by not requesting reimbursement for them [8]. However, new methods of calculating the quality of care by tracking costs for an individual Medicare or Medicaid recipient across settings will detect hidden costs. An alternative to trying to game the system would be to look at internal operations, determine what amount of nursing care is needed to prevent the most common adverse events, and then staff to minimize those events. This kind of prevention and delivery of quality care is, in fact, the intent of the new rules for reimbursement [8]. Currently, the prevention of adverse events is typically addressed in very general terms. For instance, infection-control staff and nurses who provide care are told

to "decrease infections," as if merely relaying this message will accomplish the goal. In the scenario being promoted by the new rules for reimbursement, a nurse leader would study varying staffing patterns and adjust staffing to prevent infections, and this would, in turn, be the key to the individual hospital's financial viability. In the future, for hospitals to be reimbursed, staffing must be tied to quality, just as quality will be tied to finances.

Even after the new rules take effect (the Medicare changes have already been implemented; the Medicaid changes will begin July 2012), nurses' insights will be needed to plan and implement the new structures in health care delivery. The next challenges for reimbursement will draw on the nurse executive's current skill set to plan and implement accountable care organizations [15]. Nurse executives are already experienced in providing continuity of care, including patients and families in care decisions, and designing systems with consumer involvement.

Conclusion and Recommendations

North Carolina has significant challenges to overcome if hospitals are to remain financially viable. For the good of patients, North Carolina needs to move forward in using the best information to achieve quality care and maximum reimbursement for services provided. Nurses have the insights that will be necessary for our state to accomplish both, but systemic and cultural barriers need to be removed. The following recommendations are a preliminary list of actions to be taken.

First, hospitals should recruit qualified nurses to serve on hospital boards, thus bringing insights on direct patient care into decision-making arenas. Second, schools of nursing and the North Carolina Nurses Association should establish leadership education to prepare nurses for board positions. The College of Nursing at East Carolina University is developing a graduate course on board involvement, and the North Carolina Nurses Association will establish the NCNA Leadership Academy to prepare nurses for roles on health care boards. Insights from the North Carolina Organization of Nurse Leaders should enlighten this education. Third, nurses should become educated in budgeting and finance to bring additional knowledge to bear on what care costs and on the consequences of financial decisions on patient outcomes. Fourth, nurse executives, other nurse leaders, and researchers should compare the cost of staffing with additional registered nurses with the cost of receiving no reimbursement for adverse events. Additionally, they should study the staffing needed to prevent condition-specific adverse events. Fifth, physicians, hospital administrators, and financial officers should encourage nurse involvement in

decision making, so that patients may benefit from nurses' insights. Sixth, nurses and hospital systems should work together to resolve hospital system problems that impede care and frustrate caregivers.

There are many actions that need to be taken to provide patients with the quality care they need and to secure consistent reimbursement. The involvement of nurses in decision making is one part of the solution that will help North Carolina move confidently and securely into the health care future. **NCMJ**

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