



Guest Editorial

Value-informed to Value-driven Nursing Practice



I would first like to thank Yakusheva, Rambur, Buerhaus and O'Reilly-Jacob for both of their thorough and excellent “Outlook and Perspective” contributions in the March/April, 2022 issue of *Nursing Outlook*. As nursing has matured and the issue of value in health care has now become the lifeblood of the survival of American health care, this contribution could not be more timely or vital.

I am eager to reflect on the authors' call for nurses to “begin to incorporate into their practice the responsibility to call out low value care and efficient, cumbersome administrative processes that inhibit nurse's ability to provide coordinated, high-value patient care.” (p. 213). I am reminded that value occupies two poles at each end of any continuum. Certainly, at one pole, we can all relate to value advanced through the efforts of those who have a strong commitment to making a difference, having an impact, improving conditions and circumstances, and raising the quality of the human experience. I believe the case has been adequately made that each of these are fundamental and historical drivers for the practice of nursing.

The authors have arguably well enumerated both the elements and processes associated with ethically grounded, outcomes-driven, cost-effective, and value-based nursing practice. They also emphasize that after the past two years of a pandemic-intensive experience, the uncountable deficiencies that have long existed in the health care system now make it clear that it is in both the nurses' and health systems' interest to not return to a pre-pandemic reality if we are to advance the interests of envisioning and realizing a more mutually-rewarding health future. And theirs is a powerful truth.

This is my 50th year as a nurse. Having gone through at least three major nursing workforce challenges to adequate nursing resources with a sprinkle of the myriad of periodic but regular nursing resource shortage issues, I am sensing the shadow of *déjà vu*. As I have reviewed the important publications of those times, most recently in the late 1990s and early 2000s, if we compare the wisdom of that time with the thoughtful prose of today related to both workforce and value,

one would see recurring conversations and precious little movement.

There is no doubt that what these authors state is real. *Value* advancement and sustainability are inextricably linked and will ultimately demonstrate what kind of human future we create. Nurses have the potential, supported by size, location, and their centrality to all manner of health care delivery, to play a key role in addressing and aligning the determinants of health informing a preferred healthy future. The capacity for nurses to contribute to this aim is not in question.

However, at the other end of the value pole are issues related to nurses themselves. The question is: what is the real value of nursing and nurses? A cursory review of nurses' institutional history indicates that nurses have always been identified as a cost through every period of nursing resource management over the several decades of American health care (Cryts, 2022). Like any item of cost, nurses are seen through an expense lens in the operational landscape of health care. This means that the mental model, management processes, structural framework, operational mechanics, and financial ledger, validate that nurses have always been managed “on the margin.” In the February 20, 2022 issue of the *New York Times Magazine* in the article, “Nurses have finally learned their worth,” a health system chief executive elucidated nurse's reality in starker terms: “Nursing has always been a burnout profession. The work is hard. It is physical and emotional. And hospitals build in shortages into their business model, keeping their staffs lean and their labor costs down” (Hilgers, 2022). And more recently, Jack Needleman, PhD, professor and chair of the department of health policy and management at the UCLA Fielding School of Public Health said in the May 18 issue of *Medscape News*: “executives only see that nurses are one quarter of hospital costs and thus a cost center to be managed rather than a service line to be promoted and enhanced.” Throughout my 50 years as a nurse, 45 of those years in some capacity of nursing leadership, along with many of my other nursing leadership colleagues, I have been fighting the prevailing notion of

nursing as “a labor cost.” Let’s face it, cost delineation and management of nurses as labor has definitive financial expense parameters. Cost and value simply sit on different sides of the ledger. In economics and accounting, you simply cannot convert expense into value.

Within this contextual framework, any value nurses might produce generally accrues to the institution; I do agree with Yakusheva et al. that value is a platform through which to reset the hospital/nursing relationship. However, currently, in only the most indirect or amorphous manner, does the value equation directly positively impact most nurses. Unlike physicians, the essential value quid pro quo relationship between producer and product for nurses is at best indistinct and at worse, nonexistent. It is virtually impossible to become a value producer when little in your presence or your work has any continuously enumerated fiscal value directly linked to the product of that work. As a result, at best, a nurse’s fiscal value is as a “cost controller,” a sort of margin circuit rider limited to addressing the cost s/he may or may not have played any part in generating. This restricts the nurse to addressing financial cost functions in a way that at best maximizes the margin between cost and contribution.

There is little identifiable direct value identified with nursing’s impact on fiscal contribution and its impact on quality and clinical outcome (the producer and product element of the value equation). What in this circumstance would ever sustainably enthrall the nurse to engage in the cost savings efforts of a system whose very design normatively generates continuously accelerating costs (including increasing nursing work demands) in pursuit of late-stage treatment processes which have done little to accelerate the net aggregate health of the nation at any discernable level of sustainable value? That is likely why the United States has the highest per capita price for health service and sits around 30th of all nations in the net aggregate measures of the health of its citizens. While managed as the largest expense in the system, most nurses, day in and day out, struggle to hold themselves and the health system together in the face of accelerating demands and tightly allocated human and support resources. As the pandemic clearly evidenced, most nurses in this set of circumstances keep trying to do their level best to render good nursing service to patients they truly care for and to get through the day without a major disaster. Just ask them.

In order to truly be visualized and recalibrated as a contribution center in any value equation, nursing and nurses must, in some way, move to the revenue (value) side of the ledger. I intuit that there are several major steps to which nurses must commit to make this happen:

- 1 Using macro and micro clinical and financial data already present in huge amounts in every health care system, nurses must create their own unique value algorithms that link social, clinical, financial, and practice factors that demonstrate nursing practice impact evidenced in social, behavioral, fiscal, and health status metrics that clearly enumerate nursing specific value. It is difficult to seek value if you lack the means to demonstrate utility.
- 2 It is essential to aggregate evidence of value in a way that compares intentional models or algorithms of practice with current real practices sufficient to demonstrate significant value differentiation. This must be done in a way that clearly substantiates the fiscal risks associated with failing to undertake indicated effective practice changes driving financial value associated with clinical contributions. Other major economies do this as evidenced by Learning Health Systems and Strategic Clinical Networks in the UK and Canada.
- 3 Every discipline has its own obligation to evidence its value if it is to be treated as valuable. Credit for value must be found where it is legitimately located. Value obtained is value owned. Nurses must assert ownership of obtained value (including fiscal value) joined with the value obtained by other disciplines, including their points of conjunction, without surrendering the unique contribution which is theirs. These unique contributions create the very path to health beyond the simple absence of disease. Ridding patients of a disease does not guarantee health – it is in caring and creating a goodness-of-fit between human health and the multidimensional environment addressed by the nurse that creates a context of value for human beings (Smith, 2019).
- 4 The national effort to build on value-based payment reforms and relating them to the social determinants of health stimulates the creation of a relational and intersecting set of processes which, for the first time, get at the broad cost-value interchange which includes nurses. Since it is likely that nurses will be coordinating the related service intersections, they should be at the design table as these service/payment formulas unfold. Nurses need to affirmatively keep in mind that if we are not speaking for our essential role at the fiscal and service effectiveness design table, no one else there is speaking for us.
- 5 Nurses must claim ownership over the central role we play in health care. The unspoken demonstration of our considerable power is evidenced in how we have effectively been propping up a non-sustainable health system for so long. It no longer accrues benefit to anyone to continue to do so. Health sustainability for our nation is clearly at stake. Nurses bring creative and innovative practice insights and applications to everything we do. To take great liberties with Florence Nightingale’s own words, in contemporary parlance, it is a part of nursing DNA (Nightingale, 2020). Since nursing will continue to coordinate, integrate, and facilitate

health service well into the future, nurses must make the value of this essential role apparent to all. It is necessary now for nurses to not only name this space as theirs but to demonstrate how that ownership contributes to advancing health and establishing its impact to those we serve and with whom we serve.

It is not so much that time is of the essence. In life it always is. However, this post-pandemic period provides us a stark image of what was not and is not sustainable and some insight into the work that lies ahead. Nobody more than nurses experienced the traumas of our American health system and the losses it both exhibited and exacerbated during the COVID-19 pandemic. What a great time not to recreate what does not work, along with unachieved health outcomes. Value determination and affirmation are the keystone of the work of nursing going forward. Yakusheva, Rambur, Buerhaus and O'Reilly-Jacob reflect our journey and establish some foundations to begin the work. We have much to do, a system to change, a nursing profession willing to demonstrate its value and a healthy society to create. What could be a more hopeful and important work for the nursing profession we all know lives at the center of health care.

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