Eighteen years ago, an alarming report on preventable deaths from medical errors was released by the Institute of Medicine (IOM, 2000). That report featured the estimate that approximately 100,000 people in the United States die each year because of preventable medical errors. A subsequent IOM report (2003) called for all health professionals to be better prepared to keep patients safe, focusing on five core competencies for health professions education: patient-centered care, interprofessional collaboration, evidence-based practice, quality improvement, and informatics.

Visionary leaders in nursing education were ahead of the curve, responding to the call for safer and more effective care via the Quality and Safety Education for Nurses (QSEN) project (Cronenwett et al., 2007). In 2008, the Institute for Healthcare Improvement announced a major initiative—the Triple Aim—which focuses on “simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care” (Berwick, Nolan, & Whittington, 2008, p. 759). Subsequently, Bodenheimer and Sinsky (2014) proposed a fourth—a quadruple—aim to improve the work life of health care providers, both clinicians and staff.

What progress has been made during the past 19 years since the IOM report, with 10 years of QSEN education, and 9 years after the Triple Aim was launched? Improvements in some health outcomes have been reported. For instance, the United States has seen a 15% reduction in infant mortality rates compared with 2005 (Kochanek, Murphy, Xu, & Tejada-Vera, 2014). Numbers of hospital-acquired conditions, such as central line-associated bloodstream infections (CLABSIs), pressure ulcers, and falls with injuries have significantly decreased from 2010 to 2013, according to a recent report from the American Hospital Association (2015). However, in terms of better care and lower costs, we are not yet there. James (2013) has estimated annual hospital patient deaths due to preventable harm to be over 400,000 per year. Reports from consumers of health care continue to include stories of poor care experiences, including lack of compassion and frustrations in navigating the complexities of the care system.

Further, the aim of lower costs per capita has yet to become reality. Although an estimated 20 million people were newly insured through the Patient Protection and Affordable Care Act (ACA, 2010), political challenges to the ACA remain, including rising costs, high out-of-pocket expenses, and access to affordable insurance.

The world of leadership, there is a term referred to as the sweet spot, where economic health and the common good coexist and are the keys to achieving viable and sustainable solutions (Savitz & Weber, 2008). Is it possible to reach the sweet spot of the Quadruple Aim? Academy Health and the Robert Wood Johnson Foundation are partnering to pursue this formidable aim, proposing that care delivery systems collaborate across multiple sectors to provide an affordable approach to improving population health (Hacker, 2017).

Are we as a profession just going to sit back and wait for that to happen? I believe that nurse educators are well positioned to lead the way to this lofty sweet spot goal. Nursing schools and nurse educators already work across multiple sectors to prepare nurses at all levels, from prelicensure to doctoral education. Nurse educators are already in all settings across the care continuum as practitioners themselves and as mentors to nursing students applying theory in practice. Many, if not most, prelicensure through DNP nursing students have been well prepared with the QSEN competencies. Those at the graduate level are leading evidence-based systems improvement initiatives as a part of their practice immersion and culminating projects.

I have seen the power of what nurses can do to bring the multiple sectors together in the interest of patient safety, quality, population health, and affordable care. Faculty and students have taken a Quadruple Aim approach. Working in communities and across the globe, they have engaged with community and global leaders and local health advocates, such as Promotores (lay Hispanic health advocates), to partner for better health outcomes. Faculty and students have conducted community needs assessments to identify health priorities. They have provided health education and health screening. They have applied the processes and tools of the science of improvement to community-based projects to facilitate collaboration across sectors to improve health outcomes. They have been part of teams who have provided resources that communities often cannot afford alone. They have gathered and analyzed the metrics to measure results. The response from local leaders and health advocates
is consistently positive, acknowledging their contributions. And both students and faculty have benefitted from these practice experiences.

My greatest concern is that those who lead national associations in both education and practice have not found a way to rise above their respective self-interests with a genuine commitment to work in partnership towards the Quadruple Aim sweet spot. Some have not yet learned what visionary 20th century organizational leadership pioneer Mary Follett Parker taught about the distinction between power with versus power over (Briskin, Erickson, Ott, & Callahan, 2009). Power over depends on relationships of polarity, suspicion, and differentials in power. Power with relies on relationships of respect, stakeholder engagement, and multisector approaches, resulting in co-created power.

Faculty and students typically work in collaboration with their patients and families, as well as their clinical partners across sectors, to improve health care and health outcomes. That is what QSEN has taught us. Through care coordination models, we typically collaborate in a power with stance to reach both optimal learning and optimal health outcomes, contribute to cost-effectiveness, and contribute to quality of life. Coordination of care, including patients as partners in care, is one evidence-based strategy for reaching the Triple Aim. Care coordination is a philosophy and attitude as much as it is a process. We need to teach our politicians and public officials about the care coordination model and how it addresses gaps in care in order to achieve optimal health outcomes. I have seen this facilitative education around care coordination take place when students and faculty are present at the policy table as important health care issues are addressed, specifically relating to homelessness and care for children and families who are at high risk for foster care. Conversations have moved beyond debate to generative dialogue because nurses (faculty, students, nurse leaders, and nurses as board members) have been at the table.

Faculty, students, and their preceptors could teach many organizational and political leaders by modeling how leveraging a power with approach is a viable pathway to the Quadruple Aim’s sweet spot. Power with is what makes clinical nurses, nurse educators, and nurse leaders so effective and so special. With a rising emphasis on population health, we have many more opportunities to communicate with political leaders and other policy makers. We must believe in ourselves as leaders of the Quadruple Aim and act accordingly if we are ever going to reach the sweet spot.

Power with and power ahead. What a concept!

References

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