



## Pay for Performance: A Nursing Perspective

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Pay for performance models are being put into practice with incredible urgency. According to the Agency for Healthcare Research and Quality (AHRQ), pay for performance is broadly defined as “any type of performance-based provider payment arrangements, including those that target performance on cost measures.” (AHRQ, 2006)

As healthcare providers are rapidly implementing these programs designed for meeting the requirements of pre-established quality targets, they are now examining how nursing contributes to their success. The purpose of this Nursing That Works article is to describe the history of pay for performance practices and discuss the implications for the nursing profession as a participant in this emerging movement.

### The History of Payment Systems

Prior to the 1980's, hospitals were paid in a fee-for-service arrangement. Basically, for each patient treatment or admission, healthcare providers were reimbursed in full for every case. With rising healthcare costs and a poor economy during the 1970's, the primary form of insurance for the aging population, Medicare, sought methods to classify types of patients in an effort to limit the expenses.

Under a request from Congress in 1983, a Yale University group worked with the former Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services (CMS) to develop a method for monitoring the quality of care and the extent to which services were used. In 1983, a patient classification system, entitled diagnostic related groups (DRGs), was implemented. This system, although refined and frequently updated, is the method by which many hospitals are still reimbursed today. Most hospitals are now paid a fixed amount, determined in advance for the operation cost of the DRG. Each DRG is weighted according to historical and current Medicare cost data. (Beaty, 2005).

### The New Era of Patient Safety

While the DRG method for reimbursement helped to usher in the new century for hospitals, in 2000, a landmark report by the Institute of Medicine, *To Err is Human*, stimulated public awareness in regards to patient safety. This report was an ardent motivator in promoting the adoption of new, safe practices related to quality and pay for performance. (Leape, 2005)

The pay for performance momentum was in direct response to concerns that traditional payment schemes reward the volume of services, and do not consider the quality and efficiency of health care. Public and private purchasers sought to encourage and financially reward performance improvement results. (The National Committee for Quality Health Care, 2006).

With pay for performance initiatives, healthcare providers are financially rewarded for meeting pre-established guidelines and quality incentives. Conversely, payment may be less for unfavorable outcomes. (Melia, 2006) While there is a great variety in the approach and design of programs, advocates of the pay for performance movement cite patient safety as the driving force for initiating such programs.

The Center for American Nurses is a professional association whose mission is to create healthy work environments through advocacy, education, and research.

As part of its continuous follow-up in promoting quality of care, in 2006, the Institute of Medicine released *Rewarding Provider Performance: Aligning Incentives in Medicare*. Providing confidence for the supporters of the pay for performance movement, it states that the current fee-for-service payment system “does little to promote improvements in the quality of health care”. The report calls for replacing it with a new pay for performance system for reimbursing participating healthcare providers (Institute of Medicine, September 2006).

## The CMS Guidelines

Since 2003, the Centers for Medicare and Medicaid Services (CMS), the US federal agency which administers Medicare, has conducted multiple demonstration projects designing and implementing pay for performance programs. Because many insurance companies historically follow the CMS’s lead regarding reimbursements, their current and future projects garnish national attention (Melia, 2006).

With the CMS project, Hospital Quality Incentive Demonstration, hospitals were scored on their adherence to 30 nationally standardized measures in five clinical areas, including myocardial infarction and pneumonia. Hospitals received a financial bonus that was proportional to a composite score determined from these measurements. Although the cost to implement the quality measures were arguably more than the additional reimbursement for healthcare organizations, hospital leaders involved in the pilot study stated that the project compelled the leaders and the staff to focus on continuous improvement. (Hospitals and Health Networks, 2007).

## The Case for Pay for Performance

According to one non-profit group, The Alliance for Health Reform, pay for performance programs are becoming popular because of demand from both the public and private sectors. Private sector leadership has supported this momentum because of employer and government frustration over rising healthcare costs and the “persistent deficiencies in the quality in the U.S. health care system.”(The Alliance for Health Reform, 2006).

The Alliance, with grant support from the Robert Wood Johnson Foundation (RWJF), suggests that current payment systems “not only fail to reward or encourage quality, but sometimes penalize it.” The current fee-for-

service payment systems reward health care providers each time they perform a service and do not take into account those who follow evidence-based guidelines for quality of care (The Alliance for Health Reform, 2006).

The CMS’s efforts are also gaining public momentum. The United States Congress recently mandated the agency create a plan to implement pay for performance on a much broader scale by 2009 (Melia, 2006). This plan includes withholding payment for adverse patient events as well as incentives for quality. In addition, the CMS stated that for discharges occurring on or after October 1, 2008, “hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission” (Centers for Medicare and Medicaid Services, 2008). The selected conditions include costs associated with serious preventable events, such as objects left in during surgery, hospital acquired infections and catheter associated urinary tract infections.

## Implications for Nursing

According to AHRQ, there are over 100 pay-for-performance initiatives nationwide sponsored by a variety of health plans, employer coalitions, and public insurance programs (AHRQ, 2006). These programs, which enable health care providers to give quality care while controlling cost, are either in development or already in place. These goals will be accomplished either directly or indirectly, by reducing errors and ensuring proper utilization of health care services (AHRQ, 2006).

Despite the implementation of such programs, the implications for the role of nursing has been much more difficult to define. In May of 2006, a briefing sponsored by the Alliance for Health Reform, in conjunction with the Robert Wood Johnson Foundation, *Rewarding Quality Performance: The Multidisciplinary Approach Alliance for Health Reform*, set out to define the role of nursing as it contributes to quality and high performance (Alliance for Health Reform, 2006).

## Difficulty Measuring

One of the speakers, Dr. Jack Needleman, an Associate Professor in the Department of Health Services, UCLA School of Public Health, stated that the current pay for performance systems inadequately target improvements in the core work of nursing. In his address, *Nursing and Pay for Performance*, he stated that current systems look at processes by focusing on completion of specific tasks. For example, one CMS measurement determines whether a patient admitted with a myocardial infarction received an aspirin on arrival and a beta blocker at discharge (Alliance for Health Reform, 2006).

Nursing processes, Needleman stated, are much more difficult to measure because of the inherent nature of the work nurses do. Needleman explained that nurses spend so much time multitasking and tailoring care to individual patients, that there is a challenge to measure how their specific efforts have produced single-minded results as a consequence (Alliance for Health Reform, 2007). In addition, documenting the processes that a nurse conducts is difficult, time-consuming and expensive in the current pay for performance systems.

## The Economic of Nursing

At the 2007 *Economics of Nursing Invitational Conference: Paying for Quality Nursing Care*, held at the Robert Wood Johnson Foundation, high-level sessions relating to the payment for quality nursing care were presented. The purpose of this conference was to define areas of agreement and disagreement related to payment for quality nursing care, establish strategies for research and policy, and promote action in agreed-upon areas (RWJF, 2007).

Presenting the keynote address was Linda Aiken, Ph.D., F.A.A.N., F.R.C.N., R.N., from the Center for Health Outcomes and Policy Research, University of Pennsylvania. She stated that there is growing evidence about the contributions that nurses have in pay for performance initiatives, yet most managers are not familiar with the research. She also concluded that nurses are not a focus of current initiatives and there are few examples of specific incentives that reward nurses for higher productivity and quality or cost savings. Her recommendation is to conduct further research on the impact of policy and payment changes on the nursing workforce and quality of care, and educate and motivate health care leaders to act on the basis of evidence in their management decisions (RWJF, 2007).

## Setting Standards for Measuring

Arguably, the CMS pay for performance standards were not designed specifically with nursing in mind (Alliance for Health Reform, 2007). In an attempt to create a set of nursing standards for use in inpatient hospital settings, the National Quality Forum (NQF) developed the “Consensus Standards for Nursing-Sensitive Care”

This project endorsed a set of 15 nursing-sensitive consensus standards to enhance the “evidence and understanding of the relationship between nursing-related system characteristics and patient care processes and

outcomes” (NQF, 2007). This report also addresses the implementation of the standards within healthcare organizations. According to the NQF, “The use and reporting of these consensus standards will enhance the available evidence and understanding of the relationship between nursing-related system characteristics and patient care processes and outcomes” (NQF, 2007).

## Conclusion

Pay for performance is clearly gaining momentum as the public’s access to information and the demands for patient safety are ever present within all healthcare areas. While pay for performance models seek to reward quality care and performance, the desired results could be greatly enhanced if the contribution of nurses were better quantified and recognized as essential for positive outcomes. Succinctly measuring and defining nursing care performance and quality will be instrumental in rewarding quality within any pay for performance initiatives.

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