

Charting Nursing's Future

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Reports on Policies That
Can Transform Patient Care

Perspectives on Pay for Performance in Nursing: Key Considerations in Shaping Payment Systems to Drive Better Patient Care Outcomes

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Using payment systems to drive higher quality and lower costs in health care—pay for performance—has gained significant traction among policymakers and some payers. But pay-for-performance initiatives related to nursing care are just emerging, largely because while nurses are central to patient safety and quality of care, their work remains invisible to payment systems. This brief offers the perspectives of leading experts on the challenges and possibilities

of pay for performance in nursing. These experts see pay for performance as useful in ensuring higher-quality patient care and job satisfaction for nurses, but they also see great risks if it is implemented carelessly or without sufficient nursing input. The following pages offer an overview of key barriers, potential starting points, steps to take, and unintended consequences to avoid. Experts' suggestions for policymakers appear on page 6.

Table 1 How Much Does Good Nursing Care Matter?

Adverse Events Tied to Inadequate Nursing Care	Number of Cases (Medicare FY 2007)	Cost to Medicare for Treating Condition (per hospitalization)
Pressure ulcers (stage III and IV)	257,412	\$ 43,180
Falls and trauma	193,566	\$ 33,894
Catheter-associated urinary tract infections	12,185	\$ 44,043
Vascular catheter-associated infections	29,536	\$103,027

There are significant human and financial costs for adverse events associated with inadequate nursing care. Yet quality of care can't be improved by simply demanding that nurses provide better care. The conditions under which nursing care occurs make a difference, and many of those conditions are outside the control of nurses. Designing an effective pay-for-performance system in nursing is difficult, in part, because the relationship between quality of care and the work of nurses is complex.

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Photo: David Joel/Photographer's Choice RF/Getty Images

Very ill patients, such as the woman in the photo on the left, are at risk of developing pressure ulcers. Each year, 60,000 patients die from complications related to pressure ulcers, and for those who survive, ulcers cause great pain, delay recovery and discharge, leave skin permanently at risk, and add thousands of dollars to the costs of care.

Nurses play a key role in preventing pressure ulcers by turning patients regularly, examining skin, and coordinating care with other medical professionals (see table 1 for details about the value of such nursing care). It may take six nurses to safely turn a very ill patient.

"You need the most experienced nurses, the ones with both clinical expertise and courage, to keep very ill patients from developing pressure ulcers," says Lucy Feild, PhD, RN, quality program manager, Brigham and Women's Hospital.

While pressure ulcer prevalence is considered a nursing-sensitive measure of quality, its value in pay for performance is complicated: units will have difficulty improving performance if they are understaffed or lack experienced nurses who can evaluate skin or if nurses are unable to team up to turn the sickest patients.

Pay for Performance in Nursing: Obstacles, Risks, and Advantages

Pay for performance can mean getting paid more for better-quality work or not getting paid at all for poor-quality work. It may be offered by employers to individuals (a hospital giving a bonus to executives) or to whole institutions (a payer giving bonuses or penalties to hospitals).

While nurse leaders and researchers are interested in figuring out how pay for performance can incentivize nurses to improve patient care and control costs in all settings, to date pay-for-performance programs have typically focused on hospitals and physician practices.

In a review of the literature conducted in 2007, Ellen T. Kurtzman, MPH, RN, assistant research professor, Department of Nursing Education, The George Washington University, found no examples of nursing-focused incentive programs in the United States but more than 100 such programs focused on hospitals and physician practices.

This gap exists because of several factors, such as policies that typically fail to reimburse for nursing care, institutional resistance to making nurses' work more visible when labor costs are already seen as high, lack of knowledge about the work that nurses do, and the sheer difficulty of tracking the many things that nurses do.

Although hospital care is provided primarily by nurses, current reimbursement formulas ignore the specific, unique services nurses provide and merely consider nursing as part of room and board charges. "Right now, we cannot compute nursing care's economic value because it has no price and is not on the hospital bill," says John Welton, PhD, RN, associate professor, Medical University of South Carolina.

To effectively evaluate nurses' work performance, the field needs to define nurses' work more precisely and establish smart ways of measuring its impact.

"Incentives in pay for performance should connect with what we know about quality related to nursing. Pay for performance should focus on the processes and functions that are related to nursing care and that lead to higher quality and, if not lower costs, moderation of cost increases."

Greg Pawlson, MD, MPH, executive vice president, National Committee for Quality Assurance



Experts agree that the current interest in controlling costs and improving quality will drive expansion of pay-for-performance programs and inevitably affect nurses either directly or indirectly. The experts also urge that these initiatives engage with nursing in productive ways and avoid compromising the work that nurses do for patients. "The things that are easiest to measure aren't always the most important aspects of nursing care," warns Sean P. Clarke, PhD, RN, FAAN, associate professor, University of Toronto.

Still other risks arise with poorly conceived and implemented pay-for-performance initiatives. Institutions could turn away sicker patients likely to have poorer outcomes, nurses could be burdened with more documentation requirements that keep them away from patients, and nurses and their employers could be set up to fail if evaluation of care is based on processes and outcomes outside of their control.

Yet well-designed pay-for-performance programs for nurses could make nurses' contribution to quality care more visible, increase nurse job satisfaction, and enhance the quality of patient care.

Starting Points

Health Plan Disease Prevention and Chronic Care Management Are Natural Targets for Nursing Pay-for-Performance Initiatives

Health insurers are increasingly looking for ways to improve quality of care while reducing costs. Nurses play key roles in this work by supporting preventive care and management of chronic disease.

"The kind of work that nurses do for health plans is likely to become much more common in nursing's future, and it can lend itself well to pay-for-performance initiatives," says Judith Frampton, RN, MBA, vice president, Medical Management, Harvard Pilgrim Health Care.

Nurses working for health plans monitor and assist members who have specific health conditions and gaps in their care. A nurse may, for example, call a diabetic member who hasn't seen her doctor for a while to reconnect her to preventive care or follow up with a member who visited an emergency room for a controllable condition.

"Nurses have focused on education and prevention in ways that physicians have not," says Frampton. "Given how prevalent chronic conditions are in America, in 10 years, more nurses are likely to find themselves helping people manage conditions and live healthier lives." Such programs are already taking the form of nurse

coaching programs and care management linked to physician offices.

Given the ways that nurses work when they help patients prevent and manage disease, Frampton suggests, researchers could explore whether performance improvement can be effectively incentivized by tracking the percentage of a nurse's patients who have had appropriate screenings, tests, and immunizations.

Such data is already tracked by the Healthcare Effectiveness Data and Information Set developed for health plans by the National Committee for Quality Assurance and adapted for ambulatory care settings. Experts call for research on measures that use such data in more robust ways.

Why Incentivizing Nurses' Performance Is Complex

Recent studies have documented the associations between nurse staffing and high-quality care for inpatients. Researchers have also begun identifying connections between the quality of nursing care and costs, finding that there are correlations between the number of well-prepared nurses working, the quality of care received by patients, and the savings associated with avoiding adverse events. (See *Charting Nursing's Future* 3; order information on page 8.)

Problems and Complications

"Payers recognize nurses' importance to quality and safety," says Kurtzman. "The problem is that nurses are invisible in the payment system. In hospitals, for example, their work is bundled into room-and-board charges. And any change in how nurses' time is billed would require a major overhaul of the hospital payment system."

And until recently, the current payment system was, in a sense, equivocal about poor outcomes that could be associated with inadequate nursing care. "Prevention of poor outcomes costs money and takes time. Payers' recent move to incentivize hospitals for eliminating adverse events in effect rewards them for their prevention track records. And nurses should be seen and incentivized as the hospital's army in the war against poor quality," says Kurtzman.

While institutions are not reimbursed for time that nurses spend on prevention, these payers have begun paying less for care related to hospi-

tal-acquired conditions such as infections. (See "CMS and Value-Based Purchasing.")

Incentives Can Seem Daunting

As part of a study funded by the Robert Wood Johnson Foundation, Kurtzman recently interviewed nurses, hospital leaders (such as executives and board members), and policymakers to learn more about the intersection of nursing and pay for performance. Most had not thought about incentivizing nurses, even though hospital executives routinely receive significant bonuses tied to the quality of their work.

Most nurses and administrators Kurtzman interviewed were receptive to the idea, but hospital leaders had a hard time envisioning how an incentive plan would adjust for expertise and length of employment and other workforce factors. They wondered if it would be a tough process to negotiate with the union. And when they did the math, they didn't know where the money would come from. Even a \$100 bonus for each hospital nurse adds up to a substantial sum quickly.

Research on Incentives Needed

Clearly, Kurtzman says, more research on workable incentives for nurses is needed. Policies such as pay for performance are likely to have profound intended and unintended effects on patients, health care workers, and the care environment.

Fundamentally, she says, several issues need to be resolved, including the type of payment (for example, whether it is a bonus or penalty), intended recipient of the incentive (whether it is an individual nurse, unit, service, or institution), and nature of the incentive (a cash award, professional development funds, celebration, or the hiring of additional staff).

Kurtzman is developing two new pay-for-performance models for nursing to be published in academic journals in 2010.

CMS and Value-Based Purchasing: Avoiding Adverse Consequences

Centers for Medicare and Medicaid Services (CMS) has recently begun a pay-for-performance initiative (called value-based purchasing) that relates to nursing care.

Less Pay for Some Hospital-Acquired Conditions

Since October 2008, CMS has paid less for treatment of complications that arise from eight hospital-acquired conditions, four of which are related to inadequate nursing care: falls, pressure ulcers, catheter-associated urinary tract infections, and central-line-associated infections.

CMS estimated the costs to Medicare in fiscal year 2007 for treating these conditions and found that these events, although relatively infrequent, can be quite expensive. For example, stage III and IV pressure ulcers cost more than \$43,000 per hospitalization (see table 1 on page 1).

Other payers have enacted similar payment policies for the treatment of preventable hospital-acquired conditions.

Avoiding Adverse Consequences

This shift in policy and the pressure it puts on providers comes at a time when public demand for quality of care and error reduction is high, and yet there is a shortage of nurses. At the same time, evidence shows that adequate staff and better-prepared nurses contribute to better quality of care.

Experts are concerned about the pressures that pay-for-performance initiatives will place on institutions already struggling with staffing shortages, especially those that serve vulnerable populations (for more on potential unintended consequences, see page 8).

Ideally, initiatives such as value-based purchasing should raise the standard of care, control costs, and incentivize health care teamwork, says Kurtzman.

"Payers' recent move to incentivize hospitals for eliminating adverse events in effect rewards them for their prevention track records. And nurses should be seen and incentivized as the hospital's army in the war against poor quality."



Ellen T. Kurtzman, MPH, RN, assistant research professor, The George Washington University

More Research on Measuring the Work of Nurses Is Crucial

Measurement is the most important factor in implementing pay for performance, say experts. Done badly, measurement can actually hinder quality, increase nurses' workload, and conceal important information.

"The challenge, whether you look at current models or the unique approaches of private payers, is that all pay-for-performance plans are shaped by measurement. What are we measuring? Can we be consistent? What is in the provider's control?" asks Denise Remus, PhD, RN, chief quality officer, Baycare Health System.

Some significant work has been done to develop and establish consensus on effective nursing-sensitive measures. Organizations such as the American Nurses Association (ANA) and the Collaborative Alliance for Nursing Outcomes have developed measures. The National Quality Forum

(NQF) has achieved consensus on a set of 12 measures that are sensitive to inpatient nursing care. The indicators focus on outcomes of care such as frequency of pressure ulcers and urinary tract infections associated with catheter use in ICUs.

Studies such as those supported by the Interdisciplinary Nursing Quality Research Initiative are adding to the evidence base by testing and extending current measures and developing new ones. (See "Building Evidence" on page 7.)

Clarke says that when it comes to measuring nurses' impact on care, it is crucial not to lose sight of the patient by focusing on isolated aspects of care that are easily verified but not always clearly connected to outcomes: "What would patients want to pay for if they were paying for the performance of their nurses? They would want safe,

effective treatment that allows them to attain the best quality of life possible. They would be less interested in paying for narrowly defined nursing tasks."

Ideally, says Remus, nursing sensitive-measures should be consistent, open, transparent, and publicly available. "We need good standards and operational definitions," she says.

"A critical first step toward pay for performance is to articulate what nurses do and link those activities to outcomes. Pay for performance can be a significant opportunity for nurses, but nurses themselves need to be part of the conversation."

Gerri Lamb, PhD, RN, FAAN, associate professor, Arizona State University, co-chair, Steering Committee on Care Coordination, National Quality Forum

Starting Points

Preparing for Pay for Performance in Home Health Care: Visiting Nurse Service of New York

The Visiting Nurse Service of New York (VNSNY) is the largest nonprofit home health agency in the United States. A staff of more than 12,000 allows VNSNY to care for about 31,000 people daily.

The current reporting requirements for home health care and policymakers' heightened interest in pay-for-performance initiatives

prompted VNSNY to prepare itself to demonstrate patient and agency outcomes.

Nursing Performance Scorecard

VNSNY's system collects process measures (such as documentation of care), outcomes (such as improvements in patients' ability to engage in daily life), patient satisfaction, and more. In collecting the data, VNSNY ensures that nurses get feedback on goals that are actually within their control.

The data is delivered via a secure Web site to nurses, managers, administrators, and board members in the form of an easy-to-understand quality score card. The outcomes Web site is popular with nurses, who like to check and improve their scores. "Our reporting process provides clear and timely feedback to nurses about changes they make to their clinical practice," says Ilaina Edison, BSN, MBA, vice president.

The agency is committed to not just collecting and reporting data, but actually acting on it so that nurses and leaders are continually improving performance. "Our frontline nurses have tremendous knowledge of quality improvement practices," says Carol Raphael, MA, president and CEO. "This is part of their DNA. They are invested in improving their practice."

Edison says that the process of collecting and scrutinizing this data serves to continually remind nurses of their mission. "That's where their focus should be: on helping their patients," says Edison. "There is a lot of

The Value of Nursing



Nurses who work in home health care keep patients as healthy as possible in their homes. They coordinate care among a staggering number of primary care providers and institutions. They also document their work and patients' conditions in detail.

Some populations, such as older, sicker adults, may have poor outcomes even though they receive excellent nursing care. If pay for performance ties outcomes to reimbursement without adjusting for patients' risk, such agencies will be severely disadvantaged.

Steps toward Effective Pay for Performance in Nursing

The evidence base for the effectiveness of pay for performance is still equivocal, and not enough is yet known about the unintended consequences of such pressure to link payment to particular outcomes. But the idea of linking payment and health care performance is so resonant in American culture right now that this pressure cannot be resisted, experts say, because the train has already left the station.

Experts agree that the following eight steps are essential to defining effective pay-for-performance initiatives for nursing.

Engage Wisely with Pay for Performance

No matter what the efforts are called—pay for performance, value-based purchasing, pay for quality, or something else—institutions, nurses, and researchers need to engage wisely

with this challenge: adding to the evidence base, learning about the policy, researching and documenting its implementation and consequences, and influencing future policy.

Get Broad Nursing Input

“It’s critical when it comes to pay-for-quality initiatives that nursing quality is not compromised,” says Isis Montalvo, MBA, MS, RN, director, National Center for Nursing Quality, American Nurses Association. “Everyone in nursing needs to participate in this conversation to make sure that doesn’t happen—from educators to staff nurses to advanced practice registered nurses to administrators and researchers.” The ANA is working on a set of Pay for Quality Principles (to be published in 2010) to ensure that nurses are engaged in evolving pay-for-performance discussions.

Continue Work on Nursing-Sensitive Measures

While nurses clearly play a key role in ensuring satisfactory quality of care, some experts say that a great deal of work is needed to ensure that what is measured by such efforts is actually connected with the work that nurses do. The use of established nurse-sensitive measures (such as those endorsed by the NQF) should be a key feature of any pay-for-performance efforts. Other potential measures are emerging in pilot studies. (See “Building Evidence” on page 7.)

Intensively Study Patients and the Patient-Nurse Relationship

Welton suggests that to better measure the costs and quality of nursing, institutions should develop ways of predicting which patients are at risk of developing hospital-acquired conditions and provide interventions.

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“Tying patient outcomes to reimbursement without adjusting for patients’ risk may, in effect, penalize organizations for serving the most seriously ill, frail, and vulnerable patients. Serving those patients is the heart of our mission. We have to be careful that reimbursement systems do not have incentives that would keep agencies from taking the sickest patients.”

Carol Raphael, MA, president and CEO, Visiting Nurse Service of New York



documentation in home health care, and nurses can sometimes be overwhelmed by that pressure and lose sight of their patients. This process reaffirms their work.”

The collected data makes decisions clearer for senior managers. Because everyone has access to the same information, Edison says, people embrace change at the agency more easily. “We spend more time finding solutions to problems rather than convincing people of the need for change.”

In addition, because VNSNY supports nurses’ sense of professionalism and engagement in their work, the agency is able to retain nurses in a competitive environment.

While VNSNY has embraced the project of collecting and using performance outcomes in ways that enhance patients’ and nurses’ experiences, nurses do yet receive monetary incentives for performance. In a union environment, such a step will take some time and negotiation.

Serving the Very Vulnerable

Raphael and Edison express concern about models of pay for performance that would reimburse less for poor patient outcomes.

People who have been on Medicaid their whole lives and who, at the age of 65, join Medicare, tend to be more vulnerable and stay sicker longer, perhaps because they have had less

access to care. An agency that serves a lot of very elderly people or people who have been poor their whole lives will, by some measures, have poorer outcomes than an agency that serves younger and wealthier communities.

“Tying patient outcomes to reimbursement without adjusting for patients’ risk may, in effect, penalize organizations for serving the most seriously ill, frail, and vulnerable patients,” says Raphael. “Serving those patients is the heart of our mission. We have to be careful that reimbursement systems do not have incentives that would keep agencies from taking the sickest patients.”

Any pay-for-performance model should adjust for patient risk.

They should also study the relationships between nurses and patients to better understand the effects of nursing intensity, direct nursing costs, and nurse characteristics such as experience and education.

Keep Pay-for-Performance Systems Nimble So That They Can Respond to New Information

Clarke and others say that it is crucial that decisionmakers work with what they have but keep an eye on research and new developments, such as national voluntary consensus standards endorsed by the NQF. Pay-for-performance plans should not become too rooted in what is known about nurses and quality right now, because a lot of research is ongoing.

The Value of Nursing



Photo: Image Source/Getty Images

Current payment systems fail to acknowledge nurses' work, so implementing pay for performance in nursing will be a major shift. For example, this registered nurse working in ambulatory care plays many critical roles: performing clinical procedures, assessing and documenting patients' health conditions, coordinating care, and engaging in patient advocacy and education. Yet, payers do not directly compensate for these functions.

Another obstacle to implementing pay-for-performance initiatives is the dearth of meaningful measures that capture nurses' contributions to quality and efficiency. Some promising work has begun. For example, the NQF has endorsed outcome measures that are sensitive to nurses' contributions to inpatient care. But experts agree that more research is necessary.

Effectively Address Nursing Workforce Shortages

Devise policies that end the nurse and nursing faculty shortages, expand education, and encourage the development of voluntary and mandatory programs that optimize nurse staffing levels and produce high-quality outcomes.

Develop In-Hospital Incentives for Excellent Nursing Performance

Kurtzman suggests that institutions themselves could benefit by developing incentives for excellent performance (rather than simply laboring under third-party payers' penalties for poor performance). For example, a hospital could put a certain number of dollars into a pool for nursing education when specific performance targets for the institution are met.

Allow for Nursing's Complexity and Focus Pay for Performance on Those Outcomes for Which Nurses Can Be Accountable

During one shift, nurses typically perform many complex tasks involving many patients, and their ability to do their work often depends on factors outside of their control. "High-quality care depends not only on nurses, but also on physicians, available ancillary services, the design of the work environment, the condition of patients upon admission, and the number of nurses working; it's a very complex issue," says Laura Cima, RN, MBA, NEA-BC, FACHE, vice president of nursing, Hackensack University Medical Center. "There are many components that factor into quality care and outcomes. More research is needed."

For More Information

- Visit National Quality Forum www.qualityforum.org
- Watch the ANA Web site for news about its Pay for Quality Principles www.nursingworld.org

Experts' Suggestions for Policymakers

Support and Respond to Research

- Support research on
- the effectiveness and impact of pay for performance;
 - the link between nursing care and quality outcomes;
 - how nursing intensity, academic preparation, licensure, certification, and other variables affect care cost and quality;
 - which patients are at risk of developing adverse outcomes so that nurses and institutions enhance care delivery and aren't penalized for serving at-risk populations.

Keep pay-for-performance initiatives nimble so that they can respond to new research.

Reflect Nursing's Complexity and Centrality in System Design

Demonstrate nursing's contributions to high-value health care by using nursing-sensitive indicators to measure performance and by publicly reporting the results.

Recognize the centrality of nursing and design and implement quality and pay-for-performance initiatives with nursing's contributions in mind.

Allow for nursing's complexity and focus pay for performance on outcomes for which nurses can be accountable.

Create Conditions for Quality Care

Encourage adequate nurse staffing by developing voluntary and mandatory programs that optimize nurse staffing and quality outcomes.

Design value-based purchasing to raise the standard of care, incentivize teamwork, and control costs.

End the shortages of nurses and nursing faculty.

Both quality improvement and pay for performance are difficult to achieve when nurses' work is categorized as part of patients' room and board in a hospital. The Interdisciplinary Nursing Quality Research Initiative (INQRI) funds and disseminates research on how nurses contribute to and can improve patient care. An initiative of the Robert Wood Johnson Foundation, INQRI currently funds research by 34 interdisciplinary teams.

"Through rigorous research, INQRI grantees are contributing to a better understanding of the link between good nursing care and better patient outcomes," says Mary Naylor, PhD, FAAN, RN, professor, University of Pennsylvania School of Nursing. "By understanding what nurses do to keep patients safe from medical errors, prevent costly infections, effectively manage pain, and better coordinate care, INQRI is producing evidence demonstrating why investing in nursing can improve quality and contain costs." Two examples of INQRI projects that are undertaking much-needed research follow.

The Value of Nursing



Nurses in a neonatal intensive care unit monitor and document patients' conditions and coordinate care among a team of health care professionals.

Care coordination is a term that describes the work nurses do to ensure that everything that needs to be done by everyone on a team actually happens so that the patient can be discharged. To coordinate care, nurses draw on clinical experience, judgment, and sophisticated communication strategies. Yet, nurses' care coordination work is invisible to payers, one reason that pay for performance is hard to implement for nurses.

Studying Nurses' Contributions to Care Coordination

Imagine that someone you love has just arrived at a hospital, critically in need of life-saving intervention. Now imagine leaving the hospital some time later with that same person. Think of everything that had to happen and everyone who had to be involved to get your loved one from that first moment to the last. All of that activity and all of those people are managed for the patient by nurses.

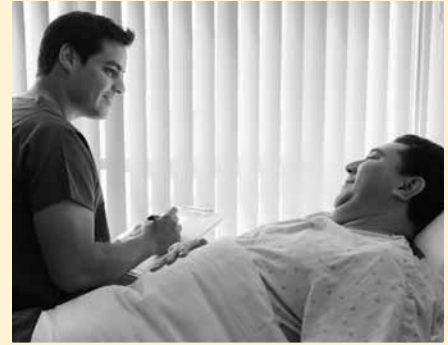
This is how "care coordination," is explained by INQRI grantee Gerri Lamb, PhD, RN, FAAN, associate professor, Arizona State University, and co-chair, Steering Committee on Care Coordination, National Quality Forum.

Lamb found that nurses themselves often have difficulty representing what they do to coordinate care. "Care coordination is more than just teamwork. It's getting the right thing done at the right time for the right outcome," says Lamb. Her study has identified specific activities nurses undertake to coordinate care, including mobilizing. Nurses mobilize members of their nursing and interprofessional team in a variety of ways to ensure patient needs are addressed in a timely and effective way.

Lamb's team has created a tool composed of six care coordination activities (including mobilizing). They will next share the tool with more nurses for their use and feedback. Ultimately, the team will refine the tool into a coordination quality indicator.

Lamb believes that nurses can bring great insight to pay-for-performance policy if they are included in the conversation: "In nursing, we have brought tremendous innovation and creativity to understanding quality of care, and we can bring that same attention and expertise to pay for performance."

The Value of Nursing



Pain has huge human costs for patients and families and economic costs for providers. Nurses are the frontline providers for pain management, and experts believe that pain should be a quality indicator in nursing. Among many other activities on any shift, nurses typically help several patients control pain. Experts cite the multitasking nature of nurses' work as another reason pay for performance is difficult to implement.

The Role of Nurses in Controlling Patients' Pain

"Nurses are key frontline providers for pain management in the hospital setting," says INQRI grantee Susan Beck, PhD, APRN, FAAN, professor, University of Utah. "Still, some pain goes unrelieved, and that affects costs, patients' length of stay, and more." Beck's team has explored how quality of care can make a difference in patients' pain.

The research has produced a tool that will allow patients to rate their experience in relation to 15 questions such as this one: "During the past shift, my nurse believed my reports about my pain." This will allow nurses to follow simple steps to monitor and address patients' pain.

The instrument was developed with the help of cancer patients and their nurses. It will next be tested at a Veterans Affairs hospital with patients who have many different diagnoses. "It would be wonderful to eventually see a pain metric added to nurse-sensitive measures like those of the NQF and ANA," says Beck.

For More Information

• Visit the INQRI Web site, www.inqri.org, for descriptions of grantee projects. Findings will be posted there as they are available.

Potential Unintended Consequences to Avoid

Pay for performance holds the promise of improving outcomes for patients, but experts warn that nurse leaders must sense the urgency of the moment and get involved in shaping pay-for-performance policies related to nursing. They and others designing pay-for-performance programs in nursing must also avoid the following unintended consequences.

Blaming Nurses for Reduced Payments to Institutions When Work Conditions May Prevent Them from Offering Adequate Patient Care

Some working conditions have been identified as critical to the safety and quality of patient care, such as the level of nurse staffing, the extent of nurse educational preparation, and the configuration of the care team. Pay-for-performance models must take such working conditions into account.

Causing Budget Shortfalls

Penalties for hospital-acquired conditions could cost institutions vital operating funds they have no way to replace.

Further Burdening Understaffed Institutions

Hospitals that are already suffering from limited resources could be further burdened with the cost of care for patient conditions that arise from not having enough nurses to give adequate care to patients.

Jeopardizing Care for the Very Vulnerable

Institutions could be tempted to select healthier patients to improve outcomes. Institutions that serve at-risk populations could be unfairly penalized.

Taking Nurses Away from Patients

Nurses may need to spend even more time away from patients documenting care. Some studies show that nurses in acute care already spend 30 percent or more of their work time on documentation.

Missing the Broader Issues

Institutions could focus too much on specific indicators named by the pay-for-performance policy and not enough on broader issues of quality and safety.

Staff Nurses Central to Quality Efforts at a CMS Premier Hospital Quality Incentive Institution

“When nurses have a voice and know that their workplace isn’t punitive, they will come forward with quality problems that need to be fixed,” says Dianne A. M. Aroh, MS, RN, NEA-BC, executive vice president of patient care and chief nursing officer, Hackensack University Medical Center (HUMC). “When they feel accountable for their patients in a personal way, the sky is the limit.”

HUMC has achieved impressive results in the CMS Premier Hospital Quality Incentive Demonstration, an initiative that offers bonuses to hospitals for quality achievements in specific areas. HUMC leaders see staff nurses’ engagement as a significant aspect of their success. They have instituted four initiatives to ensure that nurses are engaged with their practice and quality improvement:

- Nurse “champions” for pressure ulcers, falls, and pain monitor weekly staff performance at the unit level and help correct problems.
- Staff nurses participate in several oversight councils in which they exercise full voting rights.
- Staff meetings attended by leaders are scheduled quarterly at several times (including 2:00 a.m.) so that nurses can air concerns and hear about solutions.
- Senior leaders make rounds regularly to talk to staff nurses and managers about what they need to do their best work with patients. Identified problems are addressed as quickly as possible.

These and other strategies ensure that the hospital’s quality goals and nurses’ understanding and commitment to those goals are in sync. HUMC is beginning to explore incentive possibilities for nurses.

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