Legislative: Economics of Nursing Invitational Conference Addresses Quality and Payment Issues in Nursing Care

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As health care payment systems evolve toward pay-for-performance, and as quality and cost control remain concerns, providers, payers, policy-makers, and researchers have yet to consider the role of nurses in providing cost-effective, high quality care. Three key questions are: 1) How can we make a "business case" for improving and maintaining high quality nursing care? 2) Should public and private reimbursement systems specifically account for the intensity of nursing care, and if so how? 3) What are the challenges and directions for nurses in pay-for-performance (P4P)? *The Economics of Nursing Invitational Conference: Paying for Quality Nursing Care,* sponsored by the Robert Wood Johnson Foundation and the Rutgers Center for State Health Policy, held at the Robert Wood Johnson Foundation in Princeton, NJ, June 13-14, 2007, addressed these issues in a series of high-level sessions and a call to action. Conference speakers, facilitators, and attendees were leaders in nursing, economics, health care administration, and provider, payer, and consumer organizations. The presentations were thought provoking, and discussion was lively. The call to action resulted in a number of recommendations for future work, and the development of affinity groups to continue work in specific areas. Presentations will be published in a future issue of *Policy, Politics and Nursing Practice.* This Legislative Column will summarize conference presentations and discuss the recommendations and future plans made at the conference.

Summary of Conference Presentations

The Economics of Nursing Invitational Conference presentations include a Keynote Address and three sessions. The first session focused on strategies to link investments in nursing with improved quality and cost savings; the second session addressed the current challenge that the value of nursing is generally not quantified; and the third session offered challenges and directions for nursing in the P4P movement. Each of these conference segments will be discussed below.

The Keynote Address

Introducing these issues in her keynote address, Dr. Linda Aiken (Center for Health Outcomes and Policy Research, University of Pennsylvania) stated that there is growing evidence that nurses contribute significantly to quality outcomes and that this can create cost savings. Yet health care managers aren't familiar with the evidence linking nursing with quality and cost savings. Additionally, nurses are not currently a focus of P4P, and there are few examples of payment incentives that reward nurses for higher productivity and quality or cost savings.

Session One - Making the 'Business Case' for Quality Nursing Care

Linking investments in nursing with quality and cost savings--the "business case for quality nursing care"-- was the topic of the first session. The difficulty with showing a business case for nursing care, said Dr. Jack Needleman (Associate Professor, Department of Health Services, UCLA School of Public Health), is that the incentives for doing so at the institutional level are low. A quality initiative may meet social and/or economic goals because it improves outcomes and/or saves money in the health care system overall, but it may not meet the business case goal of the institution bearing the

costs because the cost savings are not captured by that institution (Miller, 2007). For example, even though it can be shown that higher nurse staffing reduces patient averse events such as falls or pneumonia and correspondingly reduces patient length of stay (Cho, Ketefian, Barkauskas, & Smith, 2003; Needleman, Buerhaus, Stewart, Zelevinsky, & Mattke, 2005) it is difficult for the institution to experience a benefit if it receives a significant proportion of revenue through per diem payments. Reductions in nurse turnover, however, have been shown to contribute to the business case through reductions in labor costs (Jones, 2005). Misalignment of social/economic and business case incentives could be corrected by payment system and other changes. Dr. Susan Horn (Vice President, Research, International Severity Information Systems, Inc., Institute for Clinical Outcomes Research) agreed and said that in long-term care there are social net *savings* related to higher RN staffing, but institutional net *costs*.

Session Two - Accounting for the Intensity of Nursing Care

A basic problem with making the business case for investments in nursing is that the value of nursing is generally not quantified. The second conference session discussed the fact that hospital reimbursement systems have historically paid for hospital nursing care on a fixed-cost basis by rolling costs up into "room and board" (Thompson & Diers, 1991). These payment systems make nursing care invisible and do not account for the variable time and effort in caring for different patients. Dr. Eileen Sullivan-Marx (Shearer Endowed Chair for Health Community Practices, University of Pennsylvania School of Nursing) said that we need to identify the work of nursing in all health finance systems using common language, while understanding the contribution of interdisciplinary care. Nursing needs to be visible in health finance.

Dr. Walter Sermeus (Center for Health Services & Nursing Research, Catholic University, Leuven, Belgium) and Dr. John Welton (Associate Professor, Medical University of South Carolina, College of Nursing) both provided evidence that putting nursing costs into room and board does not accurately reflect the costs of nursing care. Diagnosis-related-group (DRG) weights, for example, have been shown to be only weakly correlated with the amount of nursing care associated with caring for hospitalized patients (Welton & Halloran, 2005). Since nursing care consumes 30% of the total hospital operating budget and 44% of direct care costs, the cost compression of nursing care in the DRG payment system leads to significant uncorrected distortion (Kane & Siegrist, 2006). Dr. Sermeus reported that among countries using DRGs for hospital reimbursement, most do not include a nursing adjustment. The few countries that do are Australia, New Zealand, Canada, Switzerland, and Belgium. Belgium's adjustment for nursing care involves a fixed nursing cost based on minimum nursing staffing ratios, plus a variable, nursing-intensity component. One way to begin to fix the problem of paying fixed amounts for nursing care, said Dr. Welton, is to unbundle inpatient nursing care from the per diem room and board charges. This can be done on an individual patient basis or through standardized nursing- intensity weights (NIWs) (Welton, Fischer, DeGrace, & Zone-Smith, 2006). The time may be ripe for such a change. Marc Hartstein (Deputy Director, Division of Acute Care, Centers for Medicare and Medicaid Services (CMS) reported that CMS is looking into whether improvements in nursing care costing would improve relative DRG-resource weights without adding substantial administrative costs.

Research questions include:

- Can we develop a NIW measure that goes beyond hours per patient day?
- How do we determine the NIW measure (expert panel; data-driven hours of care; nursing classification systems; computerized capturing of data; or combinations of these methods)?
- How will data be obtained to develop standardized nursing-intensity weights?

The need to collect data and develop a "minimum data set" was emphasized during these discussions.

Policy issues related to nursing-intensity billing include the following:

- Whether the incorporation of nursing intensity would be revenue-neutral for the payers
- How the adjusted payments would affect individual hospitals
- Whether hospitals would buy into the change

The idea of changing DRG weights was challenged by Dr. Steve Finkler (Robert F. Wagner Graduate School of Public Service, New York University) who cautioned that the costs of doing it could outweigh the benefits. One study shows that 95% of all hospital budgets would not change more than 1% in either direction (Cromwell & Price, 1998). What will motivate payers to incorporate nursing intensity into hospital payment, said Dr. Paul Ginsburg (President, Center for Studying Health System Change), is evidence that hospitals are specializing in DRGs of high or low nursing intensity, thus indicating a need to change the reimbursement system.

Session Three - Challenges and Directions for Nursing in the Pay-for-Performance Movement

Related to the topic of reimbursement for nursing care is the current pay-for-performance (P4P) initiative. How does nursing care fit into the targets, indicators, and financial rewards of P4P? How should P4P be constructed so that targets and indicators include those achievable by the nursing workforce? Will P4P achieve its goals of improving quality? These questions pose serious challenges to designing P4P systems that engage and reward nurses for their efforts and lead to lasting quality improvement.

Dr. Sean Clarke (Associate Director Center for Health Outcomes and Policy Research, University of Pennsylvania) discussed the challenge of meeting safety and quality targets during a nursing shortage and with hospital financial constraints, noting that there is a possibility for a downward spiral in quality for agencies on the edge. Lower reimbursements could lead to even more limited resources and poorer quality of care, with even lower reimbursements. Also, the P4P quality indicators tend to be narrow process indicators that don't capture the real quality of care, especially nursing care. Hospitals can "perform to the indicators" rather than improve quality, and the documentation burdens for nurses could go up.

The Visiting Nurse Service of New York (VNSNY) will be involved in a two-year, CMS, P4P demonstration project starting in October 2007. VNSNY will meet the challenge, said Carol Raphael (President and CEO), through board and top leadership involvement, a performance measurement system, practice improvement, information technology support, incentives to nurses for meeting priority targets, and data collection and analysis.

An alternative way to promote quality, noted Dr. Jim Rebitzer (Charlton Professor and Chair, Department of Economics, Case Western Reserve University), is through high-commitment, human-resource (HCHR) systems, in which "people work hard and cleverly in the interests of the firm, in return for good pay, empowerment, trust, and interesting, fulfilling work." They do this without formal incentives because they identify their interests with those of the firm. There is mutual monitoring and pressure among employees that enforces desired behaviors. Key processes for HCHR systems are cultural transformations and the establishment of work teams among nurses, physicians, and other personnel.

To make improvements in quality, said Dr. Joanne Disch (Professor and Director, Densford International Center for Nursing Leadership, University of Minnesota; Chair, AARP Board of Directors), we need to transform organizational culture by improving the effectiveness of senior leadership and quality improvement systems. We need to emphasize nurses' contributions to societal health and choice (a key goal of the American Academy of Nursing's Raise the Voice campaign); highlight and reward organizations that are holistic, cost-effective, offer choice, and achieve good outcomes; and establish partnerships that bring together academicians, clinicians, consumers, providers, and business leaders, along with Chief Executive Officers and Chief Financial Officers.

The Call to Action

The call to action offered a number of recommendations, as well as individual pledges that will be used by conference organizers to build affinity groups that can work together in areas of common interests. Both will be outlined below.

Recommendations

The challenge is to identify the WHAT of quality nursing care and the HOW of paying for quality. Dr. Aiken recommended that we conduct 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. An important research question is whether adjusting hospital payments by a NIW would result in a more rational system. Another research topic is to compare outcomes from P4P and HCHR systems, with particular attention to impacts on nurse turnover.

One policy recommendation was to translate and disseminate the evidence we have regarding the value of nursing, and to add the 15 National Quality Forum (NQF), nursing-sensitive measures to existing P4P measures. These 15 measures are listed at the NQF website (NQF, 2006). Another policy change is to redesign the DRG system to account for the intensity of nursing care. Federal intervention to increase the supply of nurses and nurse educators is also an important policy change, since key components of quality are the ratios, proportions, and educational levels of nurses delivering care. In the long run, however, we need total health care system redesign in-order-to rationalize payment systems so that nurses have more direct time with patients, human/caring factors are increased, the skills, knowledge and scopes of practice of nurses are maximized, and providers have incentives to make lasting quality improvements.

Many of these policy changes, such as reshaping P4P, redesigning the DRG system, federal intervention to increase nurse supply, and total health care system redesign, will require extensive legislative action. A key policy stakeholder, therefore, is the government, at both the state and federal levels. Governmental engagement is key for all of these redesigns. In addition, a willingness on the part of all nurses to advocate for the changes will be needed.

Positioning nurses in strategic positions is one way to move these recommendations forward. We need to get nurse leaders at policy tables, decisions boards, leadership/CEO positions, and government positions. The Robert Wood Johnson Foundation will soon launch its *Pipeline to Placement: Getting Nurses on Boards*, a program that will match health and health care boards and commissions with an adequate number of nursing leaders who could fill those roles.

In addition to nurses being “at the table” to help with policy making, it is equally important to engage key partners to speak for the value of nurses and the care they deliver. The business community is fast realizing the value of nursing to the economic development of their communities, improved access to care, and a healthy workforce. Consumer groups, employer groups (such as Leapfrog), insurance groups, nursing unions, and other labor groups should also be engaged. This is why the Robert Wood Johnson Foundation has placed its new *Center to Champion Nurses in America* at the AARP.

Conference participants felt that one of the most effective strategies for achieving these suggestions is to “call the circle,” i.e., pull voices together on areas of agreement in order to organize for change. This could happen, for example, if a coalition of leading nursing organizations, such as *Pipeline to Placement*, continues to work to arrange for nurses to be at policy tables, decision boards, and governmental bodies.

Future Plans: Affinity Groups

At the end of the conference, participants made individual pledges that will be mailed back to them in 6 months as a reminder of their commitments while at the conference. Conference organizers will group the pledges around commonalities, and will indicate to each participant other participants who might be interested in working in their commitment area. As examples, several participants pledged to deepen the research on the topics, others said they would reach out to the business and labor communities, while still others committed to engage government officials and other policymakers. On their part, conference organizers will work to sustain the dialogue and work initiated at this conference.

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