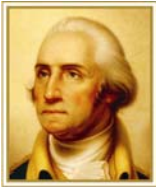


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DEPARTMENT OF NURSING EDUCATION

Nurses Wrestle with the Pros and Cons of Pay-for-Performance Plans

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- **Trends in Hospital Performance Measurement, Public Reporting, Value-Based Purchasing**
- **Impact on Nursing**
- **Findings from GW Study on Nursing Engagement**





The Quest for Health Care Excellence

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“Quality problems are everywhere, affecting many patients. Between the health care we have and the care we could have lies not just a gap but a chasm.”

Institute of Medicine, Crossing the Quality Chasm, 2001

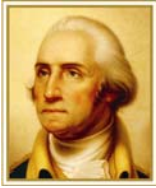


The Quest for Health Care Excellence

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“I would give great praise to the physician whose mistakes are small for perfect accuracy is seldom to be seen”

Hippocrates, ca 430 BC

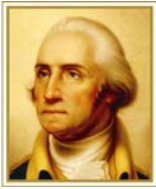


The Quest for Health Care Excellence

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“ . . . even admitting to the full extent the great value of the hospital improvements in recent years, a vast deal of the suffering, and some at least of the mortality, in these establishments is avoidable.”

Florence Nightingale, 1863

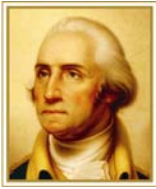


The Quest for Health Care Excellence

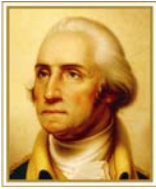
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“If a physician make a large incision with the operating knife and cure it,...., he shall receive ten shekels in money. If a physician make a large incision with the operating knife, and kill him,....his hands shall be cut off.”

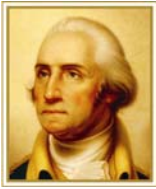
Code of Hammurabi, 1870 BC



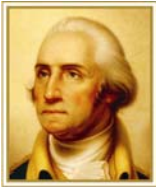
- Spotlight on significant gaps in quality health care (e.g., IOM)
- Escalating health care costs and employer impatience
- Public awareness and support for improved patient safety
- Availability of endorsed and standardized performance measures
 - Set of 15 “nursing-sensitive” standards (“NQF15”)
 - Evidence demonstrates that the size, composition, and other aspects of the nursing workforce affect these processes of care and outcomes
- Swift federal government policies enabling public reporting, pay-for-reporting, and pay-for-performance



1. Failure to rescue (death among surgical inpatients with treatable serious complications)
2. Pressure ulcer prevalence
3. Falls
4. Falls with injury
5. Restraint (vest and limb) prevalence
6. Urinary catheter-associated UTI - ICU
7. Central line catheter-associated BSIs - ICU
8. Ventilator-associated pneumonia - ICU



9. Smoking cessation counseling for AMI
10. Smoking cessation counseling for pneumonia
11. Smoking cessation counseling for HF
12. Skill mix
13. Nursing care hours per patient day
14. Practice Environment Scale-Nursing Work Index (PES-NWI)
15. Voluntary turnover



Hospital Performance Measurement and Reporting

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- NQF-endorsed™ national voluntary consensus standards for nursing-sensitive care (NQF; 2004)
- Proliferation of alliances devoted to transparency and accountability (e.g., Hospital Quality Alliance)
- Emergence of state reporting efforts focused on nursing performance (Maine, Massachusetts)
- Hospital Compare launched in 2005
 - More than 4,000 hospitals currently participate
 - 30 measures presented for comparison (26 process, 3 outcome, HCAHPS) + payment/volume data
 - HCAHPS – survey of hospital experience including nurse communication & other nursing-related items



VBP: Pay for Reporting

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- Rapid expansion of Hospital Compare under the MMA which paved the way for pay for reporting
- Pay for reporting = Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiative
- FY2009 IPPS final rule (CMS-1390-F, August 2008) expands RHQDAPU from 30 to 42 measures
 - Retires 1 pneumonia oxygenation assessment measure – hospitals not required to submit data beginning January 1, 2009
 - Increases number of measures that are required for the full APU in FY2010 by 13
 - One nursing-sensitive measures are among the required measures (i.e., failure to rescue)
 - Intent to adopt 2 additional measures (AMI and PN readmission rates) in the CY2009 OPSS/ASC



VBP: Pay for Performance

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- Pay for reporting = Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) initiative
- RHQDAPU to transition to P4P in 2009???
- Report to Congress on transition from RHQDAPU to P4P (available at:
<http://www.cms.hhs.gov/AcuteInpatientPPS/downloads/HospitalVBPPlanRTCFINALSUBMITTED2007.pdf>)
- Link payment to performance
- Hospital-acquired conditions ('HACs', 'never events') provision under FY2008 IPPS rule (CMS-1533-FC) first hospital P4P initiative



Hospital-acquired Conditions

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- Value-based purchasing reform under IPPS (CMS-1553-FC)
- Beginning with October 1, 2008 discharges, reimbursement will be eliminated for selected inpatient conditions/complications:
 - Occur during the hospitalization
 - Are preventable
 - Are secondary diagnoses
 - “Bump up” higher reimbursement

(1) pressure ulcers*

**(2) certain preventable inpatient injuries*
(i.e., fractures, dislocations,
intracranial injuries, crushing injuries,
burns)**

**(3) catheter-associated urinary tract
infections (UTIs)***

**(4) vascular catheter-associated
infections (BSIs)***

(5) certain surgical site infections (SSIs)

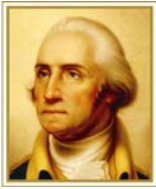
(6) objects left in surgery

(7) air embolism

(8) blood incompatibility

- CMS-1390-F required inclusion of 3 additional hospital-acquired conditions (manifestations of poor glycemic control, surgical site infections, and deep vein thrombosis/pulmonary embolism)

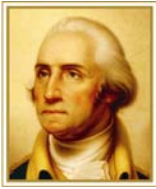
* = NQF-endorsed™ national voluntary consensus standard for nursing-sensitive care



Hospital-acquired Conditions

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- Pressure ulcers (257,412 cases of stage III and IV ulcers, \$43,180/hosp)
- Preventable injuries such as fractures, dislocations, and burns (193,566 cases, \$33,894/hosp)
- Catheter-associated urinary tract infections (12,185 cases, \$44,043/hosp)
- Vascular catheter-associated infections (29,536 cases, \$103,027/hosp)
- Certain surgical site infections (69 cases, \$299,237/hosp)
- Objects mistakenly left inside surgical patients (750 cases, \$63,631/hosp)
- Air emboli (57 cases, \$71,636/hosp)
- Blood incompatibility reactions (24 cases, \$50,455/hosp)



Hospital-acquired Conditions

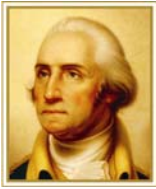
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- Manifestations of poor glycemic control
 - Diabetic ketoacidosis (11,469 cases, \$42,974/hosp)
 - Nonketotic hyperosmolar coma (3,248 cases, \$35,215/hosp)
 - Hypoglycemic coma (212 cases, \$36,581/hosp)
 - Secondary diabetes with ketoacidosis and with hyperosmolarity (data not available)
- Surgical site infections
 - Certain orthopedic surgeries (269 cases, \$148,172/hosp)
 - Bariatric surgery for obesity (37 cases, \$233,614/hosp)
- Deep vein thrombosis/pulmonary embolism following certain hip and knee replacement surgeries (4,250 cases, \$58,625/hosp)

Nursing “911”



Nurses as the “first responders”



VBP: Implications for Nursing


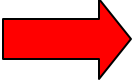
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- Growing body of evidence that links nursing care to patient outcomes
- Among specific subpopulations, evidence points to a nurse staffing-outcome effect for failure-to-rescue rates, inpatient mortality, and length of stay; effects are especially pronounced in surgical inpatients
- Nurses are drivers in coordinating, delivering, and documenting care related to RHQDAPU measures (e.g., vaccination, discharge instructions for HF)
- Higher registered nurse staffing patterns have been associated with higher quality care on AMI, HF, PNEU composite measures (Landon et al., Arch Intern Med. 2006)
- Half of the hospital-acquired conditions have been linked by the evidence to nursing and endorsed by NQF as voluntary consensus standards (i.e., pressure ulcers, falls with injury, catheter-associated urinary tract infections, vascular catheter-associated infections)



Hospital-acquired Conditions Implications for Nursing

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- Elimination of reimbursement will emphasize nursing's role in the prevention of these complications  triggering an investment in nursing?
- Studies demonstrate reductions in these complications are achievable  stimulating quality improvement?
- Reactions to negative sanctions will span continuum

Bleak

- **fiscal restraint and workforce modifications that weaken nursing**
- **“Blame game”**
- **Protectionism and avoidance of “helping” behaviors**

Bright

- **increased recognition in the value of investing in nursing**
- **strengthening of nursing systems performance**
- **Systems approach maintained**

Where is Nursing?

Engaging the Single Largest Health Care Workforce





Nursing Engagement in Performance Measurement and Public Reporting

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- RWJF-funded, 24-month project
- Responds to current policy directions that relate to transparency and accountability
- Primary aims:
 - Analyze current policy directions that impact nurses
 - Identify key issues, challenges, and opportunities through qualitative data gathered from interviews with hospital executives, nurses, hospital trustees, and national organizations of import
 - Activate and strategically engage nursing community
 - Commit to and accelerate the availability of publicly reported nursing performance data
 - Encourage and advocate for policies that recognize nurses' contributions to quality and safety
- National Advisory Committee co-chaired by Drs. Dennis O'Leary and Mary Wakefield
- Collaboration with AAN, ANA, AONE, others....



Nursing Engagement: Progress to Date

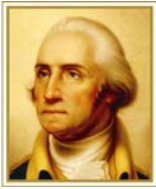
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Phase 1: Inventory and analyze current landscape (2007-08)

- ✓ Inventory of 'current state' of nursing performance measurement, public reporting of these data, and value-based purchasing
- ✓ Business case for incentivizing high quality nursing care
- ✓ Semi-structured interviews with hospital executives, nurses, trustees, and representatives of national organizations to solicit perspectives on national policy directions

Phase 2: Translate findings into actionable strategies (2008-09)

- Conceptual framework for nursing performance measurement, public reporting of these data, and value-based purchasing
- Position papers, guiding principles, and near and long-term strategies to facilitate greater penetration of incentive programs and advance policymaking that recognizes the contribution of nursing



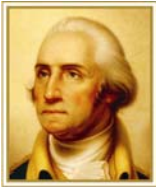
Nursing Engagement: Soliciting Perspectives on Policy Directions

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- Over 100 semi-structured interviews conducted by telephone (n=33) and in-person (n=69) during site visits to 7 hospitals/health systems
- Solicited perspectives of hospital executives (e.g. c-suite), nurses, trustees, and representatives of national organizations of import (e.g., government agencies, accreditation organizations, professional nursing organizations, labor groups)
- Content focused on perspectives related to nursing performance measurement, public reporting of these data, financial incentives to stimulate improvements in nursing quality, and responses to federal policies (e.g., CMS' hospital-acquired conditions policy)
- Descriptive analyses of demographic data and qualitative techniques derived from a modified content analysis will be used to interpret the interview data and synthesize themes



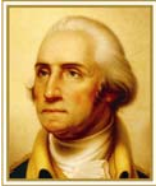
**Strengthening Nursing's
Voice in Policy**



Planning a Nursing Quality & Safety Alliance

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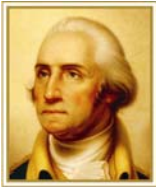
- Natural extension of GW portfolio
- 12-month RWJF-funded 'planning' grant
- Explores the nature of nursing's voice in transparency and accountability policies and the need for a unified 'policy voice'
- GW as 'neutral convener' to facilitate discussions with leaders from representatives from national nursing organizations
- Responds to key questions: How might nursing strengthen its voice in policy related to performance measurement, public reporting, and value-based purchasing? What formal arrangements, if any, should be pursued – vis-à-vis establishing a nursing quality and safety alliance – to ensure that nursing's voice is unified on these issues?



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Questions?



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