

Nurse Perceptions of Their Role in Hospital Reimbursement

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ABSTRACT

Background: Nursing-sensitive indicators (NSI's) serve to measure the impact nurses have in promotion of quality care. Existing research highlights the value-based purchasing (VBP) system implemented by the Affordable Care Act (ACA). Few studies explore nurse perception.

Method: This review provides a state-of-the-science addressing NSI's regarding delivery of quality care, hospital assessment related to value-based purchasing and the role of patient satisfaction regarding nursing care in the reimbursement of hospitals. Existing data related to nurses' roles in VBP reimbursement efforts is described.

Results: A theme in the literature is that the patient satisfaction surveys, accounting for 30% of the total performance score, impacts funds allocated by the ACA guided by patient satisfaction, thus nursing quality. A gap in the science exists in understanding nurse perceptions of their role in the process of hospital reimbursement. Future research should assess this perception of how their care impacts hospital reimbursement and healthcare costs.

Keywords: value-based purchasing, nursing-sensitive indicators, hospital reimbursement, quality care, nursing administration

BACKGROUND

The purpose of a value-based purchasing hospital reimbursement plan is to reach standards of patient care and satisfaction that fee-for-service reimbursement may not conjure. However, little evidence has demonstrated an increase in quality patient care (Werner, Kolstad, Stuart, & Polsky, 2011). The current system does not take severity of a patient's condition into consideration; this creates special problems in areas of high intensity nursing responsibility such as intensive and critical care units where patients require the most attention (Welton, Unruh, & Halloran, 2006). The intensive care unit (ICU) environment has increased demands on

employees, but the hospital does not get proportional reimbursement with this taken into consideration (Iannuzzi et. al, 2011). Boev (2012) found similar patient responses to nursing care in one of the first quality of care investigations within an ICU.

Welton and Dismuke (2008) held a study around the issue of bundled pricing for hospital nursing care. Their idea based on their hypothesis and data suggested that, rather than a bundled, flat price for the room and board of patients, the charges per room should reflect the overall intensity of nursing care required. That is, the charge needs adjustment based on the diagnosis related group and the amount of the nurse's attention required by the patient in the room. Virkstis, Westheim, Boston-Fleischhauer, Matsui, and Jaggi (2009) analyzed patient falls and pressure ulcers, two of the most notorious and preventable nursing-specific outcomes. The authors concluded that incremental costs associated with the condition went far beyond the total revenue at risk from the new payment provision. Kurtzman and Buerhaus (2008) examined how the impending changes in Medicare's inpatient prospective payment system may affect hospital nurses. Researchers concluded that nurse managers and chief nursing officers should use strategies to approach clinical complications systematically through documentation of the cost benefit nurses provide to hospitals.

Much of the literature centers on the relationships between patient satisfaction and nurse compassion together to meet the goal of high quality care. High patient satisfaction exists among units of care with a low nurse to patient ratio, and patients' benefit and satisfaction increases from consistent one on one care from the nurse (Welton et al., 2006). McClelland and Vogus (2014) summarized that when hospitals acknowledged the importance of compassion so much that nurses were incentivized, patients reported better care quality. Fox's (2016) study concluded that nurse involvement in discharge planning enhanced patient's view of the quality of their care

and reduced healthcare costs. Nurses perceived overall expectations and performance to be higher than the average patient in all five dimensions evaluated through factor analysis, which included tangibility, empathy, reliability, responsiveness, and assurance to compare patient satisfaction with hospital stay. It was understood that patients expected nurses to deliver high quality care to them and positively impact their hospital stay (Lee & Yom, 2007). Kennedy, Craig, Wetsel, Reimels, and Wright's (2013) study suggested that when the hospital professionals learned of patient feedback, quality of care improved. This demonstrated the importance of not only the nurse, but also the hospital learning from report of the patient experience.

D'Amour, D., Dubois, C. A., Tchouaket, E., Clarke, S., & Blais, R. (2014) concluded that 76.8% of the combined adverse affects were attributed to the nursing care involved in the study. Therefore, the nursing research conducted around these nursing-specific indicators that expose adverse events such as urinary infections or patient falls must influence education of nursing professionals in a culture heavily engrossed in value-based purchasing hospital reimbursement. Schreuders, Bremner, Geelhoed, and Finn (2014) discovered factors outside of the nursing professional's control contributed to the disruption of adverse-free care. Nilsson et al. (2014) developed a Nurse Professional Competence scale for self-evaluation of the competencies from various perspectives and then used this information to help healthcare organizations teach nurses the importance of nursing-sensitive indicators. Another study explored the ways in which an accurate database could exist to continually track the evolution of nursing-sensitive indicators to recognize trends and positive progression of nursing personnel evaluated by the metric (Patrician, Loan, McCarthy, Brosch, & Davey, 2010). Because nursing care will never go away,

these indicators will continue in use and evolve to help researchers study the impact of nursing actions on patient care, whether good or bad.

Another investigation provided evidence that nurses feel well led by nurse leaders and administrators when they visibly witness the presence of and actively feel communicated with by the leaders. If that is the case, a disconnect existing between hospital administrators without direct patient healthcare experience as well as nurse administrators who do not make rounds on the units or know clinical nurses personally may find themselves out of the loop when it comes to a trusting relationship with nurses (Anderson, Manno, O'Connor, & Gallagher, 2010). Blegen, Goode, Spetz, Vaughn, and Park (2011) sought to determine the relationship between nurse staffing with a baccalaureate degrees versus registered nurses with a lower degree status and found lower incidence of congestive heart failure mortality, and pressure ulcers, as well as shorter length of stay correlated with the baccalaureate prepared registered nurses. One study sought to identify and explore nurse managers and clinical nurse perceptions of quality improvement in their practices (Price, Fitzgerald, & Kinsman, 2007). The researchers discovered that individuals from each group blamed each other for areas of weakness. Nursing leaders have much to learn about how new policies such as value-based purchasing should be implemented. This was demonstrated by Buerhaus, Donelan, DesRoches, and Hess' study (2009) where data gathered showed that nurses had negative perceptions of how the policy changes would affect respect, staffing, and pay for nurses upon implementation.

The Gap

One major area deserving further investigation is clinical nurses' perceptions of their own role in the process of value-based purchasing hospital reimbursement. Patient satisfaction surveys and nursing-sensitive indicators demand that everyone involved in healthcare must stay

engaged toward the common goal of reimbursement through quality improvement. Research directed at ascertaining nurses' perceptions will outline how much and in what ways nurses are involved in the conversation.

METHODS

Study Design

This study used a qualitative descriptive study utilizing a set of 14 open-ended interview questions regarding hospital staff nurse perceptions of their role in the process of hospital reimbursement as it pertains to aspects of the value-based purchasing model such as nursing-sensitive indicators and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey.

Population and Sample

The population of interest is staff nurses within hospitals in the Knoxville region. Subjects had the opportunity to volunteer by contacting the principal investigator (PI) via email. Information for participation in the study was available via a cover letter containing elements of informed consent sent to nurse managers and/or clinical educators within the Knoxville region. Snowball sampling was used as an additional recruitment strategy by asking participants to refer colleagues. A number of participants necessary to reach saturation is not known, however this was a pilot study and five participants was the principal investigator's goal sample size. Inclusion criteria included bachelor's degree educated, English speaking registered nurses (RN) who practice in acute care settings.

Setting

Interviews were conducted either in person in a private room at the University of Tennessee, Knoxville's College of Nursing or over the phone. Both forms of interviews were

recorded on an audio recorder.

DATA COLLECTION

Staff were recruited for the study through the PI reaching out to nurses who were personal and professional contacts. Contacts were instructed to email the PI if interested in participating in the study. Participants were then emailed a copy of the informed consent to complete and either scan or hand-deliver to the PI. All interview data and participant forms and communications were kept on the password protected OneDrive for participant confidentiality purposes. A third party transcriptionist completed a confidentiality agreement and transcribed the interviews verbatim. No monetary incentive was provided to interview participants. The PI reviewed transcriptions for accuracy by reading them while listening to the audio recordings.

DATA ANALYSIS

The five interviews were recorded with an audio-recorder and typed verbatim as a transcription by a transcriptionist. Interviews were read multiple times by the PI and quotes that depicted nurse perceptions of their role in hospital reimbursement were isolated. From there, the PI labeled each quotation as a supporting subtheme. A supporting subtheme was any recurring sentiment that was shared by at least two participants. Subthemes were then grouped into a total of three major themes. Major themes were those that recurred in at least three of five interviews, making them a perception in the majority of nurse participants interviewed.

RESULTS

Theme One: Patients First!

Perhaps it seems intuitive, or an obvious common denominator based on what is known about nurses, but a major theme that the interview participants continued to come back to when answering questions in the interviews had to do with their patients. At the end of the day, the

patients these nurses served emerged as their top priority, their top motivator in all aspects of their jobs. When Participant E was asked about the attitude she walks away with when her manager discusses the nurse's role in hospital reimbursement, she responded "It just makes me like want to work that much harder to take care of people and provide good just quality care." These nurses love their patients; they express a desire to do right by their clients.

It was a common denominator for staff nurses that the overall mission was to see to it that they are serving patients well. However, the staff nurses' attitudes about issues of hospital reimbursement and how this played into the larger goal of patient care was less consistent. A common frustration for the participants was a feeling that the expectations placed on them were barriers to their care. Participant C explained that for her, "How my process is... how I treat my patients, how I treat their families, that's gonna be an issue for me... the survey that they get when they get home, that's not, it's not a priority." The survey she speaks on is the HCAHPS patient satisfaction survey, one that some but not every patient receives to evaluate their care experience while at the hospital. Participant D expressed specific thoughts upon the interference she believes HCAHPS has on patient care saying, "There's almost like too much emphasis on patient satisfaction and becoming less emphasis on patient safety and understanding your patient." Both of these nurses saw the HCAHPS survey as a specific aspect of the hospital reimbursement process that deterred from their ability to do their jobs purely as it pertained to treating their patient, as they personally believed a nurse should.

Another deterrent that two participants cited as a challenge when trying to care for their patient was an issue with supplies. Participant A shared a story during her interview in which she recalled a patient explicitly saying "help us" in regard to needing extra supplies available on the floor that the patient would not have ready access to once she returned home. Participant A

acknowledged that giving the patient extra supplies was an action frowned upon and the reason there was consistently an issue with maintaining the unit's budget. She justified her decision to provide her patient with extra supplies stating, "I see the clinical side of it." Participant C shared this same sentiment in her own interview:

"People that are asking me for extra supplies are not the people that can afford them...and so for me to say, 'Oh sorry, I can't give you that extra pack of 12 diapers...we don't get reimbursed for it.' I don't feel like I'm being a good nurse."

The interview questions may not have specifically addressed pressures of conservation of unit supplies, but for both of these nurses, this was the issue that came to their mind when they thought about the conversations they were having about the amount of money their units were receiving after reimbursement and how that fits into the bigger picture of their unit budget.

A second barrier noted by participants was the lack of communication and understanding they perceived existed between them as clinicians and the administrators communicating the expectations around these topics of hospital reimbursement. A subtheme emerged that these nurses might see their patients differently than administrators did. Participant A stated, "I feel like they don't see the patients as much, they see more the budget." Sharing a similar perspective, Participant C expressed in regard to the information presented at her unit staff meetings, "How in the same breath do you say our patient satisfaction scores are up and all this is up, but yet we've lost so much money...where it matters is it affects how I'm doing my job." With these statements both participants aimed to express a disconnect in understanding between what they were seeing on the floor, in the interaction that they have with their patients, and the expectations their superiors have in how that should manifest on paper.

In these different examples, each nurse expressed that she desired what was best for the patient she cares for, and that the role she plays in hospital reimbursement does not always make sense or seem to relate with that clinical goal. Participant A expressed, “If they pitch it towards you like, ‘this is helpful for the patient,’ they’re more than likely to do it rather than, ‘this is helpful for us monetarily as an institution.’” Nurses interviewed firmly expressed the common denominator— patients motivate their work. They understand quality patient care to be their role as a nurse. The theme emerged throughout the majority of the interviews that, in trying to meet the goals of hospital reimbursement, providing care was made more challenging.

Theme 2: It’s All About The Money

A separate theme emerged from participant responses in regard to how they feel about the general financial influence that guides the goals of hospital reimbursement with the need of the hospital to stay on top of its budget. One nurse’s perception to her role in hospital reimbursement as a nurse was her concern that some pieces of her job have less to do with patient empowered decision making and more to do with the success of the hospital. She admitted, “I guess we’re strongly encouraged...to say like ‘This is important for your baby,’ and of course it is, but um, but when you hear our managers and people talk about it, it does have a lot to do with money as well and how we’re reimbursed for the patient’s stay.” For these nurses, the recurring theme in their ideal of hospital reimbursement and the role they are asked by all of their bosses to play in it had to do with seeking monetary motivated outcomes. Good or bad, and despite the various components of their perceptions and attitudes in achieving hospital reimbursement, they saw it as a way to earn money for their institution. Participant B, who demonstrated a neutral attitude, explained her understanding as, “We are an important part of patient satisfaction and...of maintaining an adequate budget.” Participant E expressed a similar understanding stating in

regard to what she has been taught in unit meetings about her unit's supplies, "So just making sure you're not taking out too many supplies...and that saves a lot of money." Giving one example or another, all five participants seemed to hold awareness that their role in hospital reimbursement has a relationship with money.

Some participants linked their responsibilities to save the unit money on supplies as a deterrent to the level of care that they wished to provide their patients. Participant C claimed that for her, when the hospital loses money, less money was allocated to her unit. When her unit loses money, it affects how she performs her job. The majority of nurses interviewed expressed that either they personally or the nurses they work with perceived conversations with their superiors about money negatively. Participant D states, "So, when we're talking about reimbursement it's almost like, negative because, uh, it's basically coming from a standpoint that we're over budget, we've done something wrong. There's never like a happy conversation about budget." This nurse expressed a feeling of helplessness in not fully understanding why her and her peers' efforts at doing well on nursing-sensitive indicators or patient satisfaction surveys always resulted in a conversation about the budget, but seemingly never a rewarding conversation. "So it's never like a, 'Yay! Good job!' it's like 'Well, you could do better.' So, that's kind of frustrating." Because of the nature of these conversations initiated by their nurse managers and higher-level administrators, participants believed that the effort nurses put into reaching hospital reimbursement goals should equate to personal reimbursement. Participant A shared an anecdote about a time that upper level administrators spoke with the nursing staff on her unit asking what they wanted to see. The nurses mentioned that they would like to see pay increases and holiday differentials, to which Participant A says administrators responded "'If y'all start saving, and not wasting as much material then maybe we'll have a budget to allocate for that.'" Again, the

supplies issue was one that came up a lot in the participants' minds in regard to the topic of hospital reimbursement because it ultimately influenced their budget, which they perceived influenced nurses' pay.

Participant C shared a similar personal thought stating, "I think that if hospitals put such a huge...importance on scores...they should have just as much of a huge importance on paying their staff...if you get great scores, well then I should get great pay." The perception exists that the reward for paying attention to factors that affect hospital reimbursement is not equal to the effort that the nurses make and are expected to make. Three of the five nurses participating reported a negative attitude after hearing their superiors speak on their role in hospital reimbursement, and their examples to explain this response have to do with monetary pressure and not enough monetary equity given back to the nurses expected to give full participation in the hospitals goals.

Theme 3: I Love My Manager, but This Does Not Apply To Me

One of the most challenging aspects participants reported in regard to the questions they were asked in regard to their role in hospital reimbursement was an overarching feeling that these topics were not pertinent to them as staff nurses. A huge complaint of the participants was a fear that their supervisors were misunderstanding them. Participant E described that there was a definite expectation, but that her perspective was never sought out when she would like the chance to explain it, such as when hospital reimbursement goals are discussed on her unit. She explained, "And it's like, 'Okay well can you just listen really quick, as to why I'm doing this.'" In describing her point, she expressed wanting to be understood so that there could be a deeper understanding of her actions from her superiors rather than the perceived one-sided expectation. Participant A made her point that she simply did not feel that what she was asked to do was

directly relevant to her patients therefore not relevant for her to always implement these actions in her nursing care. She says:

“If it’s not specifically relevant to me and the patients that I’m caring for right then, it kind of goes in one ear and out the other... a lot of times when we’re on the floor we’re like, how does that relate to us, and I mean, we don’t see as much connection even when they try and make it.”

Who the message comes from seems to make a difference to how nurses perceived information about their role in hospital reimbursement. Participant A stated, “even if it’s something we’re like *eye roll* that’s kind of stupid, we would do it because of her.” Three out of the five interviewed participants explicitly mentioned positive impressions of their nurse managers and the effort that their nurse manager put in to communicate effectively with the staff about topics of hospital reimbursement. Participant B described her nurse manager’s efforts saying, “our manager generally tends to present things to us with a really positive outlook,... she doesn’t scold us for something we’ve done... she just focuses on how we can improve it.”

Conversely, the same feelings are not afforded to upper level administrators. These are the leaders that participants claim feeling less committed to working hard for, those that they feel less understood by. Participant A explained that the attitude staff nurses typically have about nursing leaders who come onto the floor, talk to nurses about hospital reimbursement, and leave immediately as an attitude ready to blow off the things they are saying. She stated that they “don’t know us anyway... Cause it seems like when they come to talk to us it’s just, because we’re critical to where they need to go, rather than we’re actually important.” Because a subtheme exists among the majority of the nurses interviewed that the upper level nurse leaders do not identify with their role as staff nurse clinicians, they opted not to identify with nurse

leaders. Participant C put it bluntly, “The chief nursing officer, department manager and unit manager job. That’s not my job. My job is to provide the care... I don’t have to worry about that.” Because of this feeling of irrelevance the majority of participants feel around caring about hospital reimbursement, they felt less inclined and less motivated to apply the concepts instilled in them by administration into daily care. Participant C spelled out her motivation in moving through her workday as:

“And I would say that most people feel that way that they don’t go into work thinking what, ‘The job I’m gonna do today is really gonna affect some survey score... Was your baby fed? Are they fed on time?... Were they treated with the care that they should have been treated? Is it going well?’... That’s what I’m concerned about, not are you gonna give me a 90% on nurse satisfaction.”

The concern for the majority of these nurses interviewed was that this perspective is one that is being missed because they are not being asked to give it. Participants were aware that they perceive the role they should be playing in hospital reimbursement differently than the ones directing them to think about those concepts.

DISCUSSION AND IMPLICATIONS

The purpose of pursuing this pilot research study was the gap in the current literature regarding staff nurse involvement and influence in a hospital’s success in reimbursement efforts. While the literature provides a foundation for the necessity of nurse participation in these efforts toward hospital reimbursement, consultation of the staff nurses involved in providing the care that earns the reimbursement has not been present.

When the participants shared their experiences, a priority was put on the patient experience and the nurses’ desire to make the patient the focus of their work. Their feedback

included the belief that, when the conversation is framed around the well being of the patient, the nurses respond better to what is being asked of them. They cited that the patient is their motivation, not the scores their units receive on patient satisfaction surveys and performance data. Some participants referenced a struggle with keeping a balance between supply use and budget allowance, and participants also shared the concern that administration did not view the patients the same way that the nurses did.

In regard to the monetary impact that hospital reimbursement efforts had on the nurses perceptions of their roles, their concern was that the entire process revolved around money. They admitted to having a bad attitude at times when budget was brought up to them by their superiors, and they felt that their roles as nurses was made challenging by having to work around supplies conservation. A subtheme arose where some participants were frustrated in the fact that efforts to reach reimbursement from the hospital were not reflected in their salaries.

Nurses admitted in the interviews to the thought that the topic of hospital reimbursement was not relevant to them or their patients. They mentioned not thinking about reimbursement as a part of their work, but instead as a part of nursing administration's job. Participants felt that they were not valued by administration, that they were loyal to their manager, but that administration did not understand them.

Based on responses from the five nurse participants interviewed in this pilot study, three themes were clear and could provide beneficial knowledge. The hope is for nurse leaders look to partner with their staff nurses to better communicate the need and rationale for nurse participation in pursuing hospital reimbursement and looking at it as a way to empower staff nurses in their clinical roles.

Based on interview responses, special attention should be made to the way in which nurses are communicated to in order to make them feel that they are not only relevant to the process of reimbursement, but more so that they feel that it is a conversation instead of a set of demanding expectations. In applying the feedback given by the participants, giving staff nurses a chance to provide the reasons why they maintain certain behaviors on the unit may become beneficial. Focus groups and allowing nurse managers to handle issues in which nurses need more careful explanation may allow nurses to express their views and needs more openly. These concepts may allow nurses to feel more listened to and act as partners in the pursuit of hospital reimbursement. Seeking to understand this perception and what influences it can serve as a catalyst for reaching hospital reimbursement goals both from a nursing perspective and for empowering nurses at the bedside.

STRENGTHS AND LIMITATIONS

Due to the nature of this pilot study, various strengths and limitations exist. The most significant strength of the study is the commonality between the five interview participants. Because it was a convenience snowball sampling, all five of the participants were nurses coming from the same hospital, which also happens to be a magnet hospital. There is no discrepancy between knowing if magnet status has an impact on one nurse's experience versus another because all five participants work in the same institution. Another commonality that puts the participants on an even playing field is that they have all been nurses on the unit they were working on at the time of their interview between eight months to just less than two years. Because of the narrow amount of nursing experience and only taking the perspective of nurses from one hospital, this pilot study cannot make claims for the perspectives of all nurses.

However, it certainly holds reason to ask these kinds of questions to a larger sample size with a larger range of staff nursing experiences.

The most significant limitation to the evidence is the small sample size of five participants. These participants were also young nurses with less than two years of experience and four of the five had only worked in this hospital, so it is impossible to say how someone else may disagree or have a different experience regarding the topics asked about in the interviews. Another limitation of this study includes the interview technique. Two of the five interviews occurred over the phone and three occurred in person. There is potential that the interviewer may have unintentionally asked leading questions when asking the participant clarifying questions or may have accidentally probed one participant in a way that generated more feedback than another participant. There is potential that over the course of the five interviews the interviewer could have learned of ways to ask questions or clarify questions in a way that was more beneficial to participant understanding. Lastly, the interviewer may have unintentionally validated or showed an opinion on participant answers instead of remaining neutral.

There was no member checking done in this study, and no one besides the PI read the transcriptions for accuracy including the participants. Because there was only one researcher collecting and interpreting participant data, no investigator triangulation existed to serve as a system of checks and balances.

CONCLUSION

The major finding discerned from all themes surfacing from the interviews was the lack of communication between staff nurses and the nurse leaders driving the pursuit of positive patient outcomes that are ultimately factored into hospital reimbursement. Pursuing the root of this communication barrier may provide a more beneficial relationship between the goals of

nurse leaders and nurse clinicians. Education coming from both sides about motivating factors could lead to commonalities that benefit the employee, the patient, and the hospital's budget.

The project identified the discrepancy between communication and these two groups through pursuing the perspective of those at the forefront of patient care. Those perspectives are invaluable in moving toward a more understood pursuit of hospital reimbursement from all parties and in meeting all goals. Ultimately, quality nursing care, the role of nursing administration, and the purpose of nursing sensitive indicators and patient satisfaction survey is for the betterment of the patient experience and the positive patient health outcomes. Revisiting this conversation with nurses is suggested and further research into what communication is best in pursuing a more mutual understanding of the process is a necessity in moving forward with conversations around hospital reimbursement efforts.

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