January 2017

Review of Literature: The Clinical Nurses' Perception of Their Role in Hospital Reimbursement

McKinsey Patterson
vlp555@vols.utk.edu

Follow this and additional works at: https://trace.tennessee.edu/pursuit

Part of the Nursing Administration Commons

Recommended Citation
Patterson, McKinsey (2017) "Review of Literature: The Clinical Nurses' Perception of Their Role in Hospital Reimbursement," Pursuit - The Journal of Undergraduate Research at The University of Tennessee: Vol. 8 : Iss. 1, Article 12.

Available at: https://trace.tennessee.edu/pursuit/vol8/iss1/12

This Article is brought to you for free and open access by Volunteer, Open Access, Library Journals (VOL Journals), published in partnership with The University of Tennessee (UT) University Libraries. This article has been accepted for inclusion in Pursuit - The Journal of Undergraduate Research at The University of Tennessee by an authorized editor. For more information, please visit https://trace.tennessee.edu/pursuit.
Review of Literature: The Clinical Nurses' Perception of Their Role in Hospital Reimbursement

McKINSEY PATTERSON
University of Tennessee, Knoxville
vlp555@vols.utk.edu
Advisor: Dr. Shelia Swift

This work is licensed under the Creative Commons Attribution 4.0 International License. To view a copy of this license, visit http://creativecommons.org/licenses/by/4.0/. Copyright is held by the author(s).

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 HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey, 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 nurses’ perceptions of their role in the process of hospital reimbursement. Future research should assess these perceptions of how their care impacts hospital reimbursement and healthcare costs.
1.1 Problem Statement and Significance

Nurses make up a large fraction of healthcare personnel who deliver direct patient care; their interactions with patients and the care services delivered greatly impact the patient experience. The Affordable Care Act’s (ACA) 2010 direction to the Centers for Medicare and Medicaid Services (CMS) to start a system of pay-for-performance for hospital reimbursement puts a strain on hospitals. The goal of this system is to pressure hospitals to think critically of ways to ensure the delivery of quality care to all patients. The value-based purchasing plan reallocates funds to the highest performing hospitals and adds pressure to administrators to conserve their budgets and earn more money through funding up for reallocation. This pressure drives clinicians to deliver patient care qualifying for these reallocated funds. Nursing-sensitive indicators serve as a measure of nurse delivered quality care. Catheter associated urinary tract infections (CAUTI’s), pressure ulcers, and surgical site infections serve as examples of problematic outcomes that influence hospital reimbursement. Nurses’ performances impact these outcomes and influence hospital reimbursement according to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which focuses on patient satisfaction and makes up 30% of the total performance score of a hospital.

Hospital reimbursement through the ACA’s value-based purchasing depends heavily on the nurses’ ability to minimize preventable occurrences and promote patient satisfaction. The skill and participation of nurses remains essential as hospitals continue to adapt to this relatively new policy change in the reimbursement system. Various scientists have investigated the ways in which NSIs affect value-based purchasing, delivery of quality care within nursing, and how excellence in nursing care positively benefits the hospital in ACA-allocated funding. A gap in the science exists related to the nurse’s role in actively participating in these reimbursement efforts. The quality of communication from nursing administrators concerning nurses’ role in the value-based purchasing system merits exploration to determine whether the clinical nurse’s knowledge about reimbursement goals adds work-life pressure in the process of delivering quality patient care.

1.2 Search Strategy

The purpose of this paper is to present a “state-of-the-science” concerning the role of clinical nurses in pay-for-performance hospital reimbursement. The key ideas intersecting in the review are value-based purchasing, quality of care, nursing-sensitive indicators, and hospital reimbursement. The author searched PubMed and CINAHL databases using key words such as: “hospital administration,” “quality care,” “nursing-sensitive indicators,” “hospital reimbursement,” “HCAHPS,” “nursing intensity,” “value-based purchasing,” “Medicare,” and “Affordable Care Act.” The search was limited to articles published within the last 10 years (2005 and forward), peer-reviewed journals, and the English language. These terms yielded 880 articles, 20 of which were directly relevant, and were included in this review. From the 880 articles that correlated with any combination of these terms, the 20 strategically chosen focus on the specific role of the nurse, as opposed to other health care providing professionals, in regard to a role in contributing to the achievement of reimbursement goals adds work-life pressure in the process of delivering quality patient care.

2.1 Acknowledging the Patient Perspective and Importance of Delivering Quality Care

Hospitals exist to give optimum healthcare to people who find themselves in need of their services. Hospitals function much like businesses; the politics of the operating budget factors into the delivery of quality healthcare. As such, researchers have investigated components of quality care in relation to patients, nurses, and the performance of the hospital as an institution. With the ACA’s implementation of a pay-for-performance system, one would expect that hospitals might hold themselves and their employees to higher standards of patient care. With the premise of competition to earn Medicare’s reallocated fees back to a hospital’s budget so that it does not end up in another hospital’s pocket, competition promotes excellence between institutions. The purpose
of a value-based purchasing 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).

If Werner et al.’s (2011) findings challenge the way hospitals administer care in adapting to the value-based purchasing model, then this issue secures the relationship between a patient’s care and the “nursing intensity” demanded by that patient. Nursing intensity here is defined as the amount of work and attention a nurse must apply to the care of one patient or a particular patient type in a specialized unit, and how that compares to less demanding situations. This problem resurfaces on the topic of nurse-to-patient ratio and severity of patient condition as well as diagnosis related groups (DRG). 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). Using critical care (CC) settings as an example, it is common to see these units with the smallest nurse to patient ratios. These patients have an increased risk of acute health crisis associated with a potentially life-threatening condition and need the nurse’s undivided attention around the clock. Iannuzzi, Kahn, Zhang, Gestring, Noyes, and Monson (2015) described patient satisfaction ratings; their sample was taken within an intensive care unit (ICU) yielding 658 out of 978 surveys with a response of high satisfaction from an HCAHPS survey. Boev (2012) found similar patient responses to nursing care in one of the first quality of care investigations within an ICU. These findings hold significance for two important reasons: a) reimbursement, and b) delivery of quality care in a setting where the nurse-patient ratio is low. The ICU environment has increased demands on employees, but the hospital does not get proportional reimbursement with this taken into consideration. Rather, one study further investigated by comparing the current system of charging a flat rate for all nursing care to a flat room and board rate of a hotel (Welton et al., 2006). If this trend of high satisfaction exists among units of care with a low nurse to patient ratio, patients benefit and satisfaction increases from consistent one on one care from the nurse.

Outside of the CC environment, patients see the nurse at least as often as they see any other healthcare provider since nurses spend their entire shift on the unit in which they work. Blegen, Goode, Spetz, Vaughn, and Park (2011) sought to determine the relationship between nurse staffing with a baccalaureate degree status versus nurse staffing with lower degree statuses and found lower events of congestive heart failure mortality, pressure ulcers, as well as shorter length of stay correlated with the baccalaureate prepared RNs. Data pulled from 21 University Health System Consortium (UHC) teaching hospitals over four quarters for each showed that this study is the first to demonstrate an advantage that nurse education has had on nursing-sensitive patient outcomes, though hospital acquired infections still depended most heavily on nurse to patient ratio. Blegen et. al concluded that nurse attention to nurse impacted outcomes is readily dependent on these factors.

According to a study using the American Hospital Association database, compassion focused practices were taken into account to see if any relationship between compassion and patient care quality exists in helping the patient cope under the stresses of their suffering (McClelland & Vogus, 2014). The authors summarized that when hospitals acknowledged the importance of compassion so much that nurses were incentivized, patients reported better care quality. Further, researchers discovered that in a sample of 639 nonfederal acute care United States (US) hospitals that incentivized bedside nurse compassion, those facilities performed better on the HCAHPS survey. This suggests that more is involved with quality care concerning the attitude and the nurse’s level of devotion toward the patient. The hospital’s fiscal health greatly depends on quality of care delivered to the patients served, which becomes measurable when a patient satisfaction survey suggests praises toward the nursing personnel responsible for patient comfort and a positive hospital stay.

Fox (2016) explored the results of nurse-led patient discharge plans citing that when nurses are integrated fully into the patient care from beginning to end, factors including length of stay and readmission rates are lower. Fox (2016) conducted a systematic review to analyze five databases of published trials. The findings here indicated that nurse involvement in discharge planning en-
hanced patient’s view of the quality of their care and reduced healthcare costs. A similar study based in Korea compared nursing service quality, satisfaction, and patient intent to revisit the hospital (Lee & Yom, 2007). A questionnaire was distributed to 272 patients and 282 nurses. Findings revealed that the 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. The results of this study were demonstrated via the SERVQUAL questionnaire nursing care service quality. It was understood that patients expected nurses to deliver high quality care to them and positively impact their hospital stay.

2.2 Patient-provider Communication

Patient-provider communication is another facet of the existing science. A quantitative study was carried out within an ICU surveyed with HCAHPS. Iannuzzi et. al (2015) demonstrated that communication remained key for a positive patient experience. Human contact with a patient also serves a vital role in the patient experience. If a patient considers their hospital stay experience a positive one, this may translate to the HCAHPS survey. The authors indicated that it might be in the hospital’s best interest to invest in nursing staff to ensure proper communication training. Some patients only receive significant human contact with the nurse during a hospital stay; the nurse’s ability to positively impact the patient beyond physical health maintenance has great importance to the patient as well as the hospital. A nurse must have awareness of his or her communicative effectiveness in order to address patient needs using explanatory skills, responsiveness, and active listening. The hospitals expecting these skills from their nurses must provide the education necessary to influence improvements in survey scores.

Kennedy, Craig, Wetsel, Reimels, and Wright (2013) studied the effectiveness of patient teaching and discharge teaching skills to assess for opportunity to improve a hospital’s patient satisfaction scores on the HCAHPS survey. The design of the study used a Plan-Do-Study-Act model, which researchers implemented for a quality improvement project on a vascular unit; unique to this study, the survey administrators distributed an additional patient survey in conjunction with the HCAHPS consisting of 86 questions collecting information on overall quality of care to enhance the quality of the findings. The findings of this research demonstrated that when the hospital professionals learned of the patient feedback, quality of care improved. This demonstrates the importance of not only the nurse, but also the hospital as a unit learning from report of the patient experience. In this particular study, the staff reported a feeling of empowerment from improved HCAHPS scores following the project. This report lends evidence to the notion that when a nursing team feels actively involved in providing care congruent with the goals of administrators, a culture of motivation and workplace confidence follows suit.

2.3 The Value of Nursing Sensitive Indicators in Value-Based Purchasing

Nursing-sensitive indicators have the potential to highlight mistakes nurses commonly make in the form of adverse events. Adverse events considered traceable back to nursing care include falls, medication administration errors, and pressure ulcers. (D’Amour, Dubois, Tchouaket, Clarke, & Blais, 2014). For instance, in a study conducted in Canada using a stratified sample representing a number of different patient medical units, researchers sought to “determine the severity of these events and the degree to which they are attributable to nursing care, and develop a methodology that could foster benchmarking” (D’Amour et al., 2014). The researchers 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 must influence education of nursing professionals in a culture heavily engrossed in value-based purchasing hospital reimbursement.

Nilsson, Johansson, Egmar, Florin, Leksell, Lepp, and Gardulf (2014) developed a Nurse Professional Competence scale for self-evaluation of the competencies. Competencies were created
under the belief that nurses should stay accountable for their actions in direct patient care and supervision and Nilsson’s belief that nurses’ competence is crucial for safe and qualitative care. This scale was derived from an 88-question survey given to 1,086 nurses and constructed with the intention to assist in nursing professional development. Assessing nurse competencies from various perspectives and then using the information to help healthcare organizations teach nurses the importance of nursing-sensitive indicators was the goal of this study.

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 this method of evaluating the effects of nursing care remains fairly new, the conclusion stated an important business priority of healthcare facilities acknowledging the metric is to run routine data collection on its progress. Maintaining an understanding in order to manipulate the actions of nurses would become essential to maintain positive results. Because nursing care will never go away, these indicators will continue in use and evolve to study the impact of nursing actions on patient care, good or bad.

There are a number of factors contributing to nursing-sensitive indicators that sit outside the nurse’s control. Researchers investigated over a five-year period the stays of patients at three tertiary metropolitan hospitals to explore whether factors such as patient demographic, present patient disease information, and any other relevant health information contributed to these indicators besides the nurses themselves (Schreuders, Bremner, Geelhoed, & Finn, 2014). The researchers discovered that a significant number of patients showing signs of nursing-specific outcomes were considered older adults, females, transfers from other hospitals, or intensive care patients. Thus, factors outside of the nursing professional’s control contributed to the disruption of adverse-free care. However, the study was limited based on the acuity of the patients at the time of the study. Another considerable limitation was that the hospital morbidity data did not distinguish whether health conditions presented by patients were present prior to their hospitalization, thus making it a comorbidity rather than a factor brought upon by nursing-specific outcomes.

A relationship exists between nursing care intensity, nursing-sensitive indicators, and value-based purchasing. 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. This idea gives value to the work nurses do in the hospital. One argument for why hospitals, the reimbursement process, and the general public should value the nurse’s time has to do with the nurse-intensity differences between hospital beds. In reference to the studies conducted in ICU’s, nursing skills require varying levels of challenge and one situation does not fit any one patient or any hospital unit’s experience in attempting to deliver quality healthcare. The literature discussed so far regarding value-based purchasing and the hospitals vying for its incentives seeks an understanding of the nurse’s role and the nurse’s experience on a hospital floor. Moreover, nursing-sensitive indicators that indicate error, infection, or worsening patient condition have much to do with the work intensity of the nurse and the nurse’s effort to deliver quality care. If the billing associated with this care does not consider specific nursing tasks and efforts made, then the hospitals do not have compensation for the amount of work done by the nurse. The authors acknowledged this need and implemented an investigation to examine a method of adjusting daily room charges based on nursing intensity weights associated with diagnosis related groups. From this, researchers found that their adjustment explained cost variance by 8.5% and that, by billing patients based on nurse intensity, the hospital can better explain from where cost of patient care comes. Nursing sensitive indication markers such as CAUTIs pose more of a challenge to prevent when nurses stretch their time. These investigators argue in the study that not only does recognizing nursing intensity matter in giving the nursing profession credit, but it also matters to the hospital’s efforts in budgeting and plays into their monetary goals for reaching incentives offered by value-based purchasing.
Nursing-sensitive indicators that reflect poorly on the profession may always exist because of human error, staffing conditions, and the severe health of hospital patients in relation to DRG’s. Virkstis, Westheim, Boston-Fleischhauer, Matsui, and Jaggi (2009) analyzed the patient falls and pressure ulcers, two of the most notorious and preventable nursing-specific outcomes. Investigators wanted to determine how costs associated with these two patient conditions would compare with the total revenue at risk from a new payment rule; the study was strong in that it provided detailed estimates of cost savings associated with preventing falls and pressure ulcers, but weak in the lack of widely accepted values for costs of treating these two issues. The authors concluded that incremental costs associated with the condition went far beyond the total revenue at risk from the new payment provision. The authors mentioned that the changing culture of hospital administration concerned with earning a portion of their budget back from Medicare should also concern themselves with the progress and well-being of their nursing staff because of the important relationship between the two. Quality care gets the focus it deserves when everyone invests in nurses for quality assurance; e.g. scoring well. It is significant that the same nursing-sensitive indicators that are detrimental to nurses’ image are also factors upon which the hospital depends for reimbursement.

2.4 Nurse Communication with Leadership: Nurse and Hospital Administration

Hospitals traditionally run similarly to a business. Budgeting appropriately matters to the financial success of the hospital, as well as its growth and reputation as a facility expands or develops over time. Nurses and hospital administrators may have differing perspectives and priorities. Administrators maximize funds needed to keep a hospital afloat through federal reimbursement incentives, while the clinician’s priority is providing care to patients. The problem comes when these priorities compete; this leads to a lack of communication. Adding to the mix, nurse administrators at all levels of a hospital’s hierarchy have overlapping perspectives and opinions about what to expect from each other. Nurse administrators range from unit managers to directors of nursing, chief nursing officers reporting to the chief executive officers (CEOs), up to being considered a member of the hospital administration alongside CEO’s and chief operating officers (COOs). Delivering quality care to patients remains an end goal from both the perspectives of the nurses and the administrators because quality care means value-based purchasing benefits, and it also means positive nursing-sensitive indicators. With this in common, the two groups must communicate openly and have a supportive working relationship. Because of the hierarchy, administrators have expectations of nurses. The delivery of this message could make the difference between whether the relationship between hospital administrators and nursing is viewed as a partnership or whether it is perceived as negative, causing a strain between the two groups.

Anderson, Manno, O’Connor, and Gallagher (2010) described nursing leadership as servant leadership. Their study described servant leadership as a manner of leading by putting the client or individuals ahead of the leader, and they provided an example of how constituents should behave. Servant leaders do not ask constituents to perform any task they would not perform themselves, and they shadow their own hard work to give praise and encouragement to others. This study evaluated how clinical nurses perceived the leadership of their nurse managers through the results of the National Database of Nursing Quality Indicators RN survey. The researchers conducted a focus group of nurse managers who scored above the average on the survey to explore specific qualities of these managers attributed to their success in leadership. Through these focus groups, communication and visibility were reported as key qualities. Values that were mentioned in the study included respect and empathy to foster success in their organizations. This study’s significance travels a distance in the delivery of quality leadership to clinical nurses. This investigation provided evidence that nurses feel well led when they visibly witness the presence of and actively feel communicated with by the leader. 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. The nurses in the study responded well
to the demonstration of servant leadership performed by their managers, which creates a more trusting relationship and allows them to feel successful in pleasing their superior.

Relationships between administrators and clinical nurses must foster communication. 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. Using comparative analysis they found that, while both groups identified similar solutions to ways in which nursing practice could offer quality improvement to patients, the nurse managers perceived that clinicians did not want extra work in some way. Clinical nurses perceived that their managers focused too heavily on hospital accreditation without regard to the patient.

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 (2009) in a study using an eight-page survey and a random sample of 3,500 RNs to gain predicted nurse perceptions of the new CMS policy. Data gathered showed that nurses had negative perceptions of how the policy changes would affect respect, staffing, and pay for nurses upon implementation. If nurse leaders know their staff feels negatively about policy changes related to value-based purchasing, then this knowledge might influence how they communicate with staff nurses in order to help facilitate how the change is perceived.

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. This study suggested that nurses have the capacity to make significant contributions in the budget. By promoting collaboration between three tiers of nursing leadership this study offers that a partnership should exist between these different levels of authority. Servant leadership by hospital administration may serve as necessary step. Kurtzman and Buerhaus (2008) noted that Medicare’s new aims at hospital reimbursement have the opportunity to show hospitals the worth of their nurses rather than burdening them with the measuring up under nursing-sensitive indicators. They stated, “by preventing complications and maximizing reimbursement, nurses can make the case for institutional support of nursing services, including needed improvements in staffing” (p. 32).

Kurtzman and Jennings (2008) explored how nursing performance measures contribute to the financial health of the hospital. The researchers incorporated the Nursing Quality Forum 15, helping them to better understand the successes and challenges experienced by users of the forum standards that indicated the barriers faced to widespread implementation of the performance measures. They viewed four broad categories, including importance, scientific acceptability, usability, and feasibility as well as published evidence linking these measures to nursing. The interview respondents stated, “hospitals that tend to implement nursing-sensitive performance measurement are ones that value nurses, have unwavering commitments to patients, and embody competitive spirits” (Kurtzman & Jennings, 2008, p. 239). The study respondents felt confusion on why some nurse and hospital administrators did not take the consensus standards to heart and concluded that nursing leaders must demonstrate a commitment to quality by investing in clinicians.

Clinical nurses and administrators hold stake in delivery of patient care. As nurses demonstrate a willingness to learn their role in the reimbursement process, administrators must come on board in partnering with them to build a firm knowledgebase on what these goals are in terms of value-based purchasing to prove hospital quality of care.

3.1 The Gap and Purpose Statement

One major area deserving further investigation is clinical nurses’ perceptions of their own role in the process of value-based purchasing hospital reimbursement. Research has identified that hospitals feel motivation to achieve high levels of quality care due to the demands of their institution’s budget. The process of value-based purchasing depends heavily on the quality care delivered directly to patients; as a result, there is an inherent dependence on nurses. The HCAHPS survey
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. The purpose of future research will be to investigate nurse perceptions in an area of high nursing intensity, to determine the impact of nursing-sensitive indicators on their provision of high-quality patient care. Further inquiry about the support and communication they receive from nursing administrators will also be addressed.

3.2 Limitations and Conclusion

Pay-for-performance initiatives exist in the literature prior to this date; however, the focus in this literature review relates to The Affordable Care Act's federal mandate to implement value-based purchasing and its subsequent relationship to hospital reimbursement efforts currently in existence. Though the literature offers many studies regarding quality care efforts in various aspects of the hospital including the way that nurses deliver the quality care, there is failure to recognize the importance of how clinicians may feel impacted by what is asked of nurse and hospital administrators. Additionally, the sample size was often much smaller than originally intended due to participant attrition and nonresponse rates. Few current data sets relate to nurse perceptions of the part they play in hospital's efforts to meet the demands of value-based purchasing, but these perceptions may help us better understand nurses' motivation in serving the hospital they work for and the manner in which they see themselves delivering quality care to patients.

3.3 Concept Map

![Figure 1](image_url)

References


