

# HCAHPS:

## Nursing's Moment in the Sun



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**O**n August 1, 2007, the Centers for Medicare and Medicaid Services (CMS) issued a final rule to update the hospital inpatient prospective payment system (IPPS) for fiscal year (FY) 2008. While the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) offers hospitals an opportunity to increase revenues (CMS projects about a 2% increase in reimbursements), it is definitely a mixed blessing because it necessitates even more paperwork. For nurses and consumers, however, it is an extraordinary and unexpected opportunity: for the first time, the quality of

nursing care—and patients' perceptions of the overall quality of their care—will be directly tied to hospital reimbursement.<sup>1</sup>

The impact of nursing care on patient satisfaction has long been established<sup>2</sup> but never before linked to financial rewards. In fact, based on the Press-Ganey 2005 HCAPS test data, *The Nurse Communication Section* has the highest impact on patients' overall hospital satisfaction and likeliness to recommend this hospital to others.<sup>2</sup> Moreover, the survey results will be published so consumers can compare hospitals. All patients and physicians have to do is log onto [www.hospitalcompare.org](http://www.hospitalcompare.org)

to get the comparative information they need to make informed choices about hospitalization. Physicians are likely to prefer hospitals with higher ratings, and informed consumers (including private insurers) are likely to insist on them. Thus, the final rule takes significant steps to reward hospitals for engaging in quality improvement efforts and can prove to be a marketing boon (or bane), depending on survey results.

Three broad goals shaped the HCAHPS survey. First, the survey is designed to produce comparable data on the patient perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers. Second, public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care. Third, public reporting will serve to enhance public accountability in health care by increasing the transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the HCAHPS project has taken substantial steps to ensure that the survey will be credible, useful, practical, and available to the public.

The CAHPS Hospital Survey comprises 18 patient rating and patient perspectives on care items that encompass seven key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, cleanliness and quietness of hospital environment, pain management, communication about medicines, and discharge information. Of these seven key topics, six are dramatically affected by nurses. The survey also includes four screener questions and five demographic items, some of which may be used for adjusting the mix of patients across hospitals and for analytical purposes. The entire survey is 27 questions long. There are four approved modes of administration for the CAHPS Hospital Survey: mail only, telephone only, mixed (mail followed by telephone), and active interactive voice response.<sup>3</sup>

### **FIRST SURVEY RESULTS RELEASED**

Medicare's first comparison of the HCAHPS provided some very interesting data on American hospitals. Prior to this survey, the Department of Health and Human Services published hospital mortality rates and clinical measures of performance, indicating whether hospitals appropriately treated heart attacks, pneumonia, and other conditions. However, this is the first time that the government provided comprehensive data on consumer satisfaction. And the government plans to put teeth in the results: it will stop reimbursing hospitals for these conditions effective last quarter of 2008.

The survey was meant to provide consumers with an effective way of voicing their concerns about the quality

of care they received, and it is fair to say that many patients were not satisfied.<sup>4</sup> For example, on the overall question of whether or not they would recommend this hospital to other consumers, there were substantial variations among states and between hospitals. While nation-

wide, at the average hospital, 63% of patients gave the hospital an overall rating of 9 or 10 (ie, they would recommend it). Alabama ranked high, with an average score of 73%, and Hawaii was relatively low, with an average of 52%. The average was 57% for New York, 59% for New Jersey, and 62% for Connecticut.

The data came from questionnaires completed by a random sample of patients treated at more than 2500 hospitals from October 2006 to June 2007.

Some hospitals chose not to cooperate, but they will soon have a financial incentive to do so. Beginning in the last quarter of 2008, hospitals that do not participate in Reporting of Inpatient Hospital Quality Data for Annual Payment Update will likely see anywhere from 0.4% to 2.0% reduction in their market basket updates. According to CMS, this is likely to result in a loss of about \$100 per case.

### **ADDING FUEL TO THE FIRE**

While the primary intent of HCAHPS is to help ensure consumer input, a secondary effect is to highlight the role of nurses in ensuring patient satisfaction (and now, hospital reimbursement). But the impact on nurses and nursing care don't stop with HCAHPS. The changes in FY2008 IPPS affect payment policy and will affect hospital reimbursement rates—and a number of the specific provisions will have a significant impact on nurses and nursing. For example, additional payment for cases in which one of eight selected preventable inpatient complications, errors, injuries, and infections that (if not present upon admission) could have reasonably been prevented will be eliminated in FY2009. The conditions affected by this payment reform are pressure ulcers, certain preventable inpatient injuries (ie, fractures, dislocations, intracranial injuries, crushing injuries, and burns), catheter-associated urinary tract infections (UTIs), vascular catheter-associated infections (BSIs), certain surgical site infections (SSIs), objects left in surgery, air embolism, and blood incompatibility. While CMS has indicated that this list will be augmented in future years, few can deny that nurses and nursing care are significant factors in preventing almost every one of these complications.

A recent meta-analysis of research on nurse staffing indicated that:

- Inpatient mortality is 9% to 16% lower for each additional RN FTE per patient day.

**Research on nurse staffing indicated that findings provide stunning support for the importance of maintaining appropriate staffing levels that now will also result in improved Medicare reimbursement.**

- Higher RN staffing was consistently associated with lower rates of hospital-acquired pneumonia.
- An improvement in RN/patient ratios from 1 RN/3.3 patients to 1 RN/1.6 patients reduced the odds of nosocomial sepsis by 43%, cardiac arrest by 34%, medical complications by 41%, respiratory failure by 60%, and unplanned extubation by 45%.<sup>5</sup>

These findings provide stunning support for the importance of maintaining appropriate staffing levels that now will also result in improved Medicare reimbursement.

While most, if not all, of these complications are nurse sensitive, CMS notes that nursing-sensitive performance measures are processes and outcomes—and structural proxies for these processes and outcomes (eg, skill mix, nurse staffing hours)—that are affected, provided, or influenced by nursing personnel but for which nursing is not exclusively responsible. However, while nursing-sensitive measures are quantifiably influenced by nursing personnel, the relationship may not be causal<sup>1</sup>; available evidence demonstrates that focused quality improvement activities produce dramatic improvements in falls, pressure ulcers, UTIs, BSIs, and SSIs.<sup>6-10</sup> Generally, these improvements resulted from senior leadership's commitment and investments in infrastructure, data management, and performance measurement processes, as well as systematic improvement strategies. In all cases, nurses were central to the effort.<sup>11,12</sup>

## IMPLICATIONS FOR NURSING LEADERS

Under the current system, nursing care is, as it has always been, a fixed overhead cost, reimbursement for which has been held constant within the routine and intensive care cost centers even though nursing care actually is a highly variable direct cost. Nursing resources, time, expertise, and intensity are not directly correlated with individual patient needs, which fails to recognize the differences in specific patient care costs.<sup>13</sup> This effectively prevents weighting nursing intensity<sup>14</sup> and unbundling them from fixed overhead costs.<sup>15</sup>

To maximize Medicare reimbursement under current and anticipated CMS regulations, nursing and hospital leaders must:

- Take all steps necessary to provide safe care (particularly with regard to those processes and outcomes that are measured, publicly reported, and tied to reimbursement), including research-based recommendations for safe staffing<sup>16</sup>
- Evaluate and analyze the overall clinical and financial impact of these federal policy changes on their respective institutional staffing practices
- Create a business case for patient safety based on evidence-based nurse staffing standards and practices
- Educate nursing staff and other personnel who come in contact with patients about the impact their individual behavior has on the hospital's bottom line. A program for orienting all employees to HCAPS should be a required in-service, and when the hospital's scores

are released, the data should be reviewed with employees and the scores compared with other hospitals, asking the employees to identify ways they can help improve them.

## GOING BEYOND HCAHPS

Develop a program for the public about HCAHPS and what they mean to them and to the health care system. If we are going to move the *transparency* and *consumer* agenda forward, we need to help consumers understand what the data mean and how they can use the survey to change the hospital, their community, and care providers. We even might want to develop a consumer advocacy program that captures care delivery across the continuum, rather than just the acute care hospital.

Going beyond HCAPS to involve consumers in all aspects of the care delivery system will lead to consumer-driven health care. Not only would consumers of the future be able to make choices about hospitals, they also would have the information they need to show costs and quality ratios across the care continuum for themselves and their family members.

We are shifting to a different world order. We now have an opportunity to make a real difference because CMS and other payers are looking to nursing for solutions and noticing and measuring nursing's contributions to patient outcomes. CMS is already positioning nursing at the center, with the conditions present on admissions. Now we are going to be held accountable for the nurse-sensitive patient outcomes identified years ago. Nursing and consumer collaboration needs to be explored (eg, working with the AARP as a means of collectively achieving desirable consumer outcomes and, in the process, reinforcing nurses as the most trusted professionals in America).

Chief nursing officers who have a clinical affiliation with a school of nursing should ensure that all faculty and students entering the hospital for a clinical learning experience understand HCAPS and begin to incorporate the transparency, consumerism, and economics of care into their learning experience. This is another opportunity to cost out nursing and demonstrate the value of our services.

Maybe the stars finally are lining up for nursing to be seen as a revenue-producing department: nursing will be measured on its contribution to the solvency of the nation's hospitals. We have the opportunity to demonstrate that what we do indeed makes a difference—and we will be held accountable for it!

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