Nursing: *Essential to Healthcare Value*

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Nursing is a practice discipline and occurs as 1 nurse and 1 patient, family, or community at a time. The encounter between a nurse and patient forms a fundamental bond that defines, not only nursing as a profession, but each individual nurse as a provider of care. Nursing practice drives value, and nurses have a direct and intimate influence on the quality, safety, and costs of patient-centered care. If we define nursing value as the function of outcomes divided by costs,[1] there is a need to better define the measures and analytics for patient-level costs and outcomes of nursing care. This fundamental shift to capture the patient or consumer impact of nursing care is an important expansion of how nursing value is quantified. This will require rethinking how we view nursing care delivery beyond solely measuring nursing in terms of tasks or ratios and staffing levels, to one that recognizes the individual and collective accomplishments and results provided by each nurse across the broad spectrum of care. True nursing value can only be described by measurement of the clinical and financial impact of nursing care.

PERFORMANCE-BASED NURSING CARE

This article raises a provocative question: should we focus our attention on the care provided by individual nurses? Current quality and safety activities examine unit or hospital-level outcomes for many nurses and many patients, for example, the rate of pressure ulcers or patient falls per unit or department each month. There is certainly a need to minimize these errors; however, there is little scrutiny on the care provided by individual nurses and whether patient care needs are identified and met. In a recent *Time Magazine* article, Steve Brill recommended each physician be subject to pricing and service delivery standards.[2] This approach links the practice of medicine to the actual cost of the services delivered to patients. If nursing care was linked in the same way to both the quality of the services provided and the outcomes and costs of care, would that provide the necessary incentives to improve overall nursing care delivery and impact the cost of 1 of the largest components of the healthcare sector?

Should there be greater incentives for nurses in a pay for nursing performance (P4NP) arrangement? The question gets to the heart of what nurses do for patients. New measures of nursing performance must be clinically and operationally meaningful. One option is to adopt the recently announced Choosing Wisely program by the American Academy of

Nursing.[3] The proposed 5 items address key aspects of hospital nursing care such as getting older patients mobile and minimizing use of fetal heart rate monitoring (*Box 1*). Other metrics could be used in other clinical settings such as coordination of care, surveillance of the patient over time, pain management, and patient education. Consider surveillance and pain management. Both begin with an assessment of the patient or family then clinical judgments by the nurse determine optimum treatments or interventions. For example, in a hospice setting, 1 goal would be to minimize pain and discomfort but also to allow family members to interact with the patient. How often does a nurse assess pain and comfort and utilize pharmacological and other interventions? There is very little research on how nurses use pro re nata (PRN) narcotics or the practice differences in medication administration across nurses over time.

It is increasingly possible to measure many aspects of patient-level nursing care through existing data in the electronic health record (EHR) and compare and contrast across settings, across patients, and across nurses.[4] New metrics could include how often pain was assessed, the frequency of PRN narcotic use, and how often and when a patient was reassessed and how well a nurse manages pain, for example, decreasing pain scores. Summary data could be compared across multiple nurses to allow benchmarking of best practices to determine the pattern of pain management and narcotic PRN doses across different patients and nurses. Which patients experience the most pain, and what are the alternative interventions provided by nurses? What are some of the potential negative quality measures from pain intervention, e.g., constipation and bowel impaction through use of opioids? How do we incorporate this knowledge into competency development? These questions can be answered with data and excellence in nursing practice and could be rewarded in a pay for performance model possibly tied to value-based purchasing.

In a value-oriented approach, the practice of nursing care is examined in relationship to the results for example improving quality of life or quality of dying rather than nursing tasks and their associated time. This raises compelling questions about poor nursing performance. For example, nurses with significantly fewer pain assessments or higher usage of narcotics compared to the practice setting norms could be identified and competency addressed. Existing data systems can be programmed to extract and summarize these data in near real time environments so that information can be provided to nurse managers and leaders in a timely manner.

THE CURIOUS CASE OF NURSING COSTS

There are a number of issues that hide the contribution of nurses to patient care. First, patient-level nursing costs are unknown. At best, nursing care is expressed as average hours and costs per patient day in acute care. In other settings, care delivered by nurses is subsumed within other operational costs such as a clinic appointment or home health visit. This averaging approach hides clinically meaningful variation in nursing care delivered to each patient such as the time and expertise expended by each nurse relative to the services provided, as well as the identification of problems, interventions. and outcomes assessed and treated. Essentially, nursing care is invisible within the healthcare finance system. Traditional staffing-based metrics or nurse-to-patient ratios are outdated and inconsistent with the healthcare reform vision and value-based purchasing. The argument is that in order to better understand nursing value, we need to understand the relationship between individual nurses and patients, and develop ways to measure resources expended for each patient, including the patient-level time and costs for nursing care as a component of the total direct cost for a patient or consumer during an episode of care.

How will nursing care be viewed within emerging bundled payment schemes? Nursing time and costs vary by patient, across different care settings, and within individual patients, but there is no link between actual care, billing, and reimbursement. Hospitals and other healthcare settings that do not know their true patient-level nursing time and costs are at a distinct disadvantage in emerging payment models. The intent of healthcare reform is to optimize efficiency, productivity, and quality and reduce overall costs, and it is difficult to make optimum business decisions under these circumstances without good information. Developing accurate patient-level measures of nursing care time and costs will allow nurses and other healthcare leaders to evaluate and monitor nursing care in a more comprehensive manner. For example, will an elderly patient recovering from surgery for a femur fracture benefit from an extra day in the hospital or early transfer to a skilled nursing facility for rehabilitation services? If the cost of an extra day in the hospital is lower than the costs of a day of stay in a rehabilitation setting, it makes sense to extend the hospitalization, all other things being equal. It will be necessary to have both patient-level nursing cost and direct care hours as well as data for each day of stay to support such a value-based decision-making

Box 1. Choosing Wisely: 5 Things Nurses and Patients Should Question

1. Don't automatically initiate continuous electronic fetal heart rate monitoring during labor for women without risk factors; consider intermittent auscultation first.
2. Don't let older adults lay in bed or only get up to a chair during their hospital stay.
3. Don't use physical restraints with an older hospitalized patient.
4. Don't wake the patient for routine care unless the patient's condition or care specifically requires it.
5. Don't place or maintain a urinary catheter in a patient unless there is a specific indication to do so.

Adapted from AAN.[3]