Hospital Nurses
Performance-Based Payment Incentives Increase Burden And Blame For

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ABSTRACT  We interviewed hospital leaders and unit nurses in twenty-five hospitals between June and October 2008 to explore the effect of performance-based incentives. Interviewees expressed favorable impressions of the impact that incentive policies have on quality and safety. However, they raised concerns about the policies' effects on the nurse workforce. Their concerns included the belief that performance-based incentives would increase both the burden and the blame for nurses without corresponding improvements in staffing levels, work environment, salaries, or turnover. To maximize the intended policy impact without jeopardizing the workforce that holds the key to their adoption, we recommend that policy makers invest in implementation support, redesign hospital incentives to reward teamwork, and involve nursing leaders in the design of future incentive policies.

The US health care system is considered to be among the most advanced in the world, but it is also fragmented, expensive, and unreliable. The Institute of Medicine (IOM) and Medicare Payment Advisory Commission (MedPAC), among other groups, have called for the adoption of performance-based financial incentives to achieve greater value.2,3 The purpose of this paper is to describe the perceived effects on hospitals of performance-based financial incentives, generally, and Medicare's hospital-acquired conditions policy, in particular. The latter represents the federal government's first major effort to link reimbursement to specific quality-of-care goals. Given the composition of the hospital workforce and nurses' direct involvement in inpatient care, we emphasize the potential impact of these emerging policies on hospital leaders, nurses, and the quality of care provided.

Performance-Based Incentives
Performance-based incentives are tools intended to induce provider behavioral change to foster performance improvement and add value.2 These incentives can take various forms but typically pay bonuses to providers for demonstrated improvements in the quality of care. Today more than half of commercial health maintenance organizations (HMOs)4 and state Medicaid programs5 operate pay-for-performance programs. Medicare is also adjusting its reimbursement rates to reward quality through various incentive programs.

When the Centers for Medicare and Medicaid Services (CMS) launched its first hospital performance-based incentive program in 2003, participating hospitals reported positive results, including major improvements in care for heart failure, heart attacks, and pneumonia.6 These successes fueled policy makers' support for pay-for-performance through the Affordable Care Act of 2010.

In the interim, hospitals received their first "dose" of Medicare performance-based payment policy with the October 2008 implementation of the hospital-acquired conditions policy. Under this policy, CMS reduces payments to hospitals
for patient care that results in preventable complications such as catheter-associated urinary tract infections or pressure ulcers.

**Effectiveness Of Performance-Based Incentives**

Despite Medicare’s commitment to performance-based purchasing and its specific implementation of the hospital-acquired conditions policy, evidence of the impact of these programs is difficult to assess. Initial estimates suggested that the hospital-acquired conditions policy would prevent thousands of patient complications and deaths and would save $20 million annually in direct payments. However, current analyses suggest that the specific conditions targeted by the policy are rarer and less costly than anticipated. Nonetheless, a growing amount of correlational research links better nurse staffing and practice environment variables (such as nurse manager support) to lower rates of four of the ten hospital-acquired conditions: pressure ulcers, falls with injuries, catheter-associated urinary tract infections, and vascular catheter-associated infections. A survey of 3,500 registered nurses conducted before the policy’s implementation found that a clear majority (65 percent) perceived that the policy would increase their work. These associations underscore the importance of understanding the effects of performance-based incentives on hospitals and the nurse workforce.

**Study Data And Methods**

We conducted seventy-seven semistructured interviews with hospital leaders and unit nurses in twenty-five hospitals between June and October 2008. Fifty-nine of the interviews were conducted with respondents from seven hospitals. To assess generalizability, we conducted the remaining interviews with a single respondent from eighteen additional hospitals. We also administered a short five-point Likert survey during these interviews.

We used a two-stage, purposive sampling strategy. First, twenty-five acute care hospitals were recruited based on a range of institutional characteristics such as location, size, and ownership. We recruited at least one hospital each from among the states that publicly report nursing performance (for example, Maine and Massachusetts), hospitals that had been recognized for nursing excellence by the Magnet Recognition Program, and hospitals whose nurses are represented by a labor organization. Ultimately, seven hospitals from each of four census regions (East, South, Central, and West) agreed to a site visit, during which respondents were interviewed by the study’s principal investigator.

Second, we deliberately recruited subjects with diverse experiences and perspectives who were well qualified to speak to the range of issues of interest. We ultimately interviewed forty-five hospital executives, including fourteen chief executive officers (CEOs), sixteen chief nursing officers (CNOs), and fifteen other types of executives (such as chief financial officers); eight board members; and twenty-four unit nurses, including nurse managers and staff nurses.

The taped and transcribed interviews, each lasting approximately one hour, explored informants’ knowledge of, experiences with, and perceptions of Medicare performance-based incentive programs and how these policies influence and reflect the contributions of nurses. Two interviews with hospital executives were lost to technical problems, reducing the total sample to seventy-five subjects from twenty-four hospitals.

We used well-established qualitative data analysis techniques to condense narrative data into meaningful categories and themes. Computer software (Atlas.ti, version 5.0) enabled us to code and organize discrete responses to the open-ended items. Two members of the research team independently coded a small sample of transcripts to strengthen coding reliability.

We developed thirty-two codes that applied to all seventy-five interviews, and we created 3,247 quotations with these codes. Based on coding frequency across the different respondent categories, nine topics emerged.

Because of the small sample of board members, for the quantitative analysis of the Likert items, we combined board members’ survey responses with those from the executives into a “hospital leadership” composite for comparison with the unit nurses. For each item, response categories of “very significant” and “significant” were combined for comparison with the remaining three categories.

Testing of significant differences between the leadership and unit nurses was by Fisher’s exact test (two-sided). Because of subjects’ knowledge of various issues, the applicability of certain topics to respondent subgroups (for example, items about employee compensation), and overall study design (in-person versus telephone interviews), not all items were completed by each respondent.

**Study Results**

We generated three major themes from the topics that emerged from the open-ended interviews, supplemented with quantitative data from
the Likert surveys. For each theme, we present findings from the interviews, including the percentages of coded data (as a gauge for the frequency of mentions and concerns about various topics)\(^{13}\) and supporting interview quotes followed by survey responses detailed in Exhibits 1 and 2.

In general, qualitative and quantitative results on related topics and themes were consistent with each other, unless otherwise noted. The three themes reveal interviewees’ perceptions of performance incentives as a mixed blessing, with potential benefits for patients but potentially serious, negative consequences for nurses.

**IMPROVED CARE, CONSTRAINED RESOURCES**

Among all topics that emerged from the interviews, respondents most frequently mentioned the effect of incentives on improving quality. More than 22 percent of interview responses concerned the hard work of performance improvement, evolution of hospitals into learning organizations, and hospitals’ competitive drive to be the best. Informants provided rich examples of hospitalwide campaigns to eradicate safety problems, such as pressure ulcers and hospital-acquired infections, to which incentives are linked.

Respondents also mentioned concerns about the financial impact of incentives nearly as frequently during interviews as they mentioned incentives’ effect on quality improvement (22 percent of responses). As one hospital executive said, “As much as we talk about quality, …it is the money that really matters.”

Across all respondent categories, subjects conveyed the need to maximize their hospitals’ reimbursement under expanding performance-based payment initiatives and manage the negative, unintended consequences of linking payment to performance.

During interviews, respondents were also quick to recognize the “trickle-down” effect of reduced reimbursement on nurses—that losses in Medicare reimbursement could result in budget cuts to nursing, which represents approximately 40 percent of hospitals’ direct care budgets.\(^{16}\) Nurses were particularly concerned that fewer resources would be accompanied by reductions in staff, more work, and less time at the bedside. For these respondents, any promising effects of performance-based incentives on quality were viewed cautiously because of uncertainty about their financial implications.

These mixed impressions revealed during interviews also were reflected in respondents’ responses to the Likert items. For example, when asked to rate the significance of pay-for-performance respecting various performance di-

**EXHIBIT 1**

*Respondents’ Views On The Effects Of Hospital Performance-Based Payment Policies*

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Percent rating outcome as significant or very significant</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PAY-FOR-REPORTING AND PAY-FOR-PERFORMANCE</strong></td>
<td>Leaders (n=20)(^a)</td>
</tr>
<tr>
<td>Improving patient outcomes</td>
<td>82</td>
</tr>
<tr>
<td>Improving patient safety</td>
<td>88</td>
</tr>
<tr>
<td>Improving patient satisfaction/perception of care</td>
<td>69</td>
</tr>
<tr>
<td>Increasing hospital revenue</td>
<td>69</td>
</tr>
<tr>
<td>Increasing nursing salaries</td>
<td>27</td>
</tr>
<tr>
<td>Improving teamwork</td>
<td>60</td>
</tr>
<tr>
<td>Reducing nurse turnover</td>
<td>28</td>
</tr>
<tr>
<td>Increasing demands on nurses</td>
<td>65</td>
</tr>
<tr>
<td>Reducing nursing unit budgets</td>
<td>18</td>
</tr>
<tr>
<td>Diverting nurses away from direct patient care</td>
<td>47</td>
</tr>
</tbody>
</table>

**PAY-FOR-NURSING-PERFORMANCE**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Leaders (n=31)(^c)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving nurse recruitment</td>
<td>58</td>
</tr>
<tr>
<td>Improving nurse retention</td>
<td>49</td>
</tr>
<tr>
<td>Reducing turnover and absenteeism</td>
<td>38</td>
</tr>
<tr>
<td>Accelerating improvements in patient outcomes</td>
<td>92</td>
</tr>
<tr>
<td>Accelerating establishment of culture of safety</td>
<td>75</td>
</tr>
<tr>
<td>Improving work environment for nurses</td>
<td>50</td>
</tr>
</tbody>
</table>

*Source:* Authors’ analyses of survey data.  *Note:* Nonresponses and missing data have been eliminated. \(^a\)Sample includes 12 executives and 8 board members. Because of missing data, sample size ranges from 15 to 17 per item. \(^b\)Because of missing data, sample size ranges from 21 to 23 per item. \(^c\)Because of missing data, sample size ranges from 23 to 24 per item. Board members and nurses were not asked about these effects.
mensions, a majority of respondents rated such programs as having a highly significant (“significant” plus “very significant”) impact on improving patient outcomes, safety, and satisfaction. In contrast, pay-for-performance was viewed as increasing the demands on nurses and having little effect on reducing nurse turnover or increasing nurses’ salaries (Exhibit 1).

**Mixed Feelings About Extending Incentives**

Based on the interviews we conducted, there was widespread agreement that the roles of nurses in responding to performance incentives were critical. One board member said, “My impression is...that you cannot do anything in quality if you do not involve the nurses in a significant way.” All interviewees recognized the contributions of nursing to improving performance and facilitating the critical data-gathering and -analysis activities on which the incentive infrastructure rests. Nearly 13 percent of all interview responses concerned this topic.

Given their general acknowledgment of nursing’s key roles in improving quality and safety, respondents were asked specifically whether performance-based incentives should be directed to nurses in exchange for their contributions to high performance. Performance incentives are typically paid to physicians, hospitals, and other providers, rather than directly to staff nurses—individually or collectively. Therefore, hospitals would have to determine how to allocate any incentive payments designated for nurses.

Nonetheless, respondents were generally supportive of applying the pay-for-performance concept to nurses, saying, for example, “I think that [incentivizing nurses] would be great. That is how you get somebody’s attention.” A small number of interviewees—spread generally across the respondent categories—were appalled at the idea of extending incentives to nurses. As one nurse stated, “Nurses should produce high quality regardless. …That’s what they get paid to do already.” These respondents viewed patient safety and health care quality as “job 1” for nurses and a professional value that should not be financially induced.

Regardless of their specific views, nearly all interview subjects had difficulty envisioning the details of a pay-for-nursing-performance model and were skeptical that such a system could be made operational. Diversity of the nursing workforce (such as variations in work schedules and shifts, or the use of “float” personnel who work throughout the hospital on a variety of nursing units) contributed to the perceived complexity and raised serious concerns about the challenges involved in achieving parity.

Introducing another dimension, a small number of hospital leaders’ responses (3 percent) supported team-based incentives, citing the need for fairness. “I have not thought about incentivizing any particular party in an isolated fashion. …I don’t think of it as doing something
Nurses may be vulnerable to expanded workloads and negative work-environment effects.

for nursing [per se]. Nor do I think about doing something for environmental services or for respiratory,” said one hospital executive in an interview.

Hospital executives interviewed during site visits (n = 31) were invited to respond to a specific Likert item quantifying their attitudes toward nursing incentives (Exhibit 1). Consistent with their views about incentives in general, 92 percent of executives rated the potential effects of pay-for-nursing-performance programs as likely to be significant in improving patient outcomes.

Three-fourths of the executives rated the effects as likely to be significant in enhancing hospitals’ culture of safety. At the same time, far fewer of these respondents perceived such programs as likely to have significant effects on improving nurse recruitment or retention, reducing nurse turnover and absenteeism, or improving the nursing work environment (Exhibit 1).

Burden And Blame Anticipated Fourteen percent of all interview responses related to the burdens associated with incentive policies. Respondents specifically mentioned the additional personnel, technology, training, and documentation systems needed to support an array of incentive programs.

However, they usually could not quantify these investments, articulate whether they might be offset by the payments received, or articulate a clear business case along either positive or negative dimensions. One executive stated, “What CMS does not take into consideration is the high cost that we [bear in] implementing [these policies,] ...our professional liability costs, ...the cost of the staff. ...So, you start to wonder [whether] this regulation is truly valuable.”

Notably, during interviews, nurses spoke twice as frequently of these burdens as hospital leaders did (24 percent versus 10 percent) and almost always in the context of their effects on patient care and the nursing work environment. As one nurse cautioned, “[Participation in performance-based payment policies] has increased our workload, and it takes us away from the patient’s bedside a little bit.” For nurses, time spent documenting care or complying with new incentive policies resulted in time away from the bedside and systemwide strains on nurse staffing.

Respondents also rated the specific effects of the hospital-acquired conditions policy on a Likert scale (Exhibit 2). Informants’ response patterns were generally consistent with those revealed in their survey responses about pay-for-performance.

In both cases, respondents rated these policies as having a more significant impact on improvements in hospital care and less impact on reducing nurse turnover, improving nurses’ satisfaction, or improving the nursing work environment. Notably, nearly all respondents recognized the hospital-acquired conditions rule’s likely impact on increasing the complexity of admission assessments and, predictably, the documentation burden.

Perhaps most disconcerting were views expressed in survey responses regarding the rule’s potential effect on creating an environment in which nurses would be blamed for the occurrence of hospital-acquired conditions. Although the majority of all respondents viewed this relationship as highly significant, hospital leaders were less likely than unit nurses to hold this view (p = 0.05).

Discussion

Policy Implications This study provides important insights into the perceived impact of expanding incentives on hospitals and their nurse workforces. The results underscore the promise of these programs, but they also acknowledge their potential threats and negative downstream consequences.

As policy makers contemplate more-elaborate incentive programs, these findings may be particularly instructive. We identify and discuss possible solutions intended to maximize these policies’ favorable outcomes without jeopardizing the workforce that holds the key to their adoption.

▸ OFFSET THREATS TO NURSE WORKFORCE: The overall burdens and specific disruptions experienced by hospitals as a result of incentives can be anticipated and counterbalanced. Nurses, who bear major responsibility in the adoption of these policies, may be vulnerable to expanded workloads and negative work-environment effects.

Investments in education and training, infrastructure (physical plant improvements), infor-
mation technology and decision support, and additional clinical and administrative staff can help nurses implement these policies effectively. Medicare, which will realize cost savings associated with these policies, should bear at least some of the responsibility for these investments.

However, investments to improve efficiency might turn out to be more costly than the efficiencies they actually achieve. For this reason, the effect and magnitude of these contributions should be monitored and justified by a return on investment.

▸ BUILD NONPUNITIVE WORK ENVIRONMENTS: All personnel should be held accountable for their contributions to care delivery, with nurses no more or less than others on the health care team. In particular, many interview subjects identified blame that hinders collegiality and impairs workers’ morale as a naturally occurring by-product of performance-based incentives but one that should not be tolerated.

Teamwork and collaboration, which are unlikely to be intuitive, need to be strengthened. Interprofessional education and training should be strongly encouraged to foster mutual collaboration, joint decision making, and shared goal setting among nurses, physicians, and other health professionals. In the longer term, financial incentives may be needed.17

▸ STRENGTHEN NURSING’S LEADERSHIP ROLE: Nurses are on the front line of virtually all health care delivery and have a keen awareness of its shortcomings. Nurses should be viewed as customers of and vital resources for the design and implementation of payment policy, including performance-based incentives. Yet their contributions are rarely visible or valued in policy development.18

As the Institute of Medicine has recommended, policy makers should ensure nurses’ access to policy development by establishing leadership positions designated for them. In turn, nurses should prepare to assume these leadership positions.19

▸ EVALUATE EFFECTS OF PERFORMANCE-BASED PAYMENT: Respondents’ generally positive perceptions of pay-for-performance, coupled with the lukewarm ratings of the hospital-acquired conditions policy and similar requirements in practice, suggest that hospital leaders and unit nurses may hold more hope for incentives conceptually than they do for those they have experienced to date. In reality, little is known about the actual impact of performance-based payment policies on hospitals and their workforces.

Development of an evidence base that clearly delineates the benefits, threats, costs, and returns of performance-based payment policies is badly needed. Both the public and private sectors should make further examination of incentive programs’ impacts on patient outcomes, hospital performance, patient care environments, and the health care workforce a high priority. That said, thoughtfully crafted incentive programs are needed and should not be delayed even in the absence of perfect knowledge.

CONCLUSION In this study of hospital leaders’ and nurses’ perceptions about performance-based incentive policies, nurses were acknowledged as important catalysts in achieving the quality-of-care goals induced by financial rewards yet largely invisible in their development and expression. Opportunities to mitigate this concern should be exploited to improve both outcomes for patients and the work environment for nurses.

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NOTES

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In this issue, Ellen Kurtzman and her coauthors report on nurses’ and hospital leaders’ attitudes toward performance-based incentives. They note that the results raise concerns about the effects of incentive policies on the nurse workforce, and they recommend involving nursing leaders in the design of future policies.

Several of the authors have been collaborating on this research for two years. “The most surprising finding was that [nurses] often did not see their work directly related to the pay-for-performance policies that are being promulgated by payers, such as the Centers for Medicare and Medicaid Services,” says Kurtzman. Yet it is largely the nurses’ own work that is being measured, she says, through such metrics as numbers of pressure ulcers and catheter-associated urinary tract infections.

Lead author Kurtzman is an assistant research professor in the School of Nursing at the George Washington University. For more than a decade she has specialized in patient safety and health care quality. She has been the lead investigator for several studies. She also has worked with colleagues at the University of Pennsylvania School of Nursing to advance a model of care for chronically ill elderly patients. She has worked for national health care organizations, including the American Health Care Association and the American Red Cross. She earned a bachelor’s degree in nursing from the University of Pennsylvania and a master of public health degree from the Johns Hopkins University.

Dennis O’Leary
is president emeritus of the Joint Commission.

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Kelly Devers is a senior fellow at the Health Policy Center, Urban Institute. Her main areas of research are provider payment and competition, and the organization and delivery of care. Having published widely in health care journals, she lent her specific expertise in qualitative research to this study, Kurtzman says. Devers earned master’s and doctoral degrees in sociology, with a specialization in organizations, from Northwestern University. Devers is a postdoctoral Robert Wood Johnson Foundation Scholar in health policy research at the University of California (UC), Berkeley, and UC San Francisco.

Ellen Dawson is senior associate dean for academic affairs at the George Washington University School of Nursing. She has more than twenty years of experience in teaching and more than thirty years of clinical experience. Dawson earned a nursing diploma from Newport Hospital School of Nursing and master’s and doctoral degrees in nursing from George Mason University.

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