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Testimony of the American Organization of Nurse Executives (AONE) before the Senate Finance Committee's Roundtable on the Centers for Medicare and Medicaid Services (CMS) Hospital Value-based Purchasing (VBP) Program Implementation Plan
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Mr. Chairman, Ranking Member and Roundtable participants, my name is Dr. Carol Watson, President of the American Organization of Nurse Executives (AONE), a subsidiary of the American Hospital Association (AHA) representing over 6,000 registered professional nurses in executive practice in the United States and abroad. I have been a nurse for 38 years and the Senior Vice President of Clinical Services and Chief Nurse Executive at Mercy Medical Center, Cedar Rapids, IA for 20 years. Mercy Medical Center is a stand-alone community hospital with 445 beds which offers a full continuum of services to the over 120,000 residents of Cedar Rapids and Linn County Iowa.

Value-based Purchasing: The Nurse Executives Perspective

As required by the *Deficit Reduction Act of 2005*, the Department of Health and Human Services (HHS) on November 21, 2007 delivered its report on value-based purchasing to Congress and shared it with the public on November 26, 2007. The report lays out a variety of options for a value-based purchasing plan Medicare can use to pay hospitals, but it stops short of actually recommending a specific design that could be implemented. As a nurse executive, my foremost concern, and one echoed by my AONE & AHA colleagues, is that any system that is implemented not be used punitively and arbitrarily to reduce payments to hospitals. This would be devastating to hospitals and have untoward negative consequences to not only these institutions but also to the nursing staffs who comprise the largest segment of hospitals' workforce and the communities that they serve.

A workable value-based system must be fair and provide incentives that will improve quality and performance. The following 6 principles developed by AHA and supported by AONE present a consensus viewpoint of incentives supported by many in the healthcare community.

Incentives should:

1. **Link hospital and physician incentives**. To be effective, incentives must align with those of hospitals and physicians by encouraging **all** to work toward the same goals of improving quality and patient safety, providing both effective and appropriate care, and creating better health outcomes. Physician buy-in and alignment is extremely important to the nursing staff, as it is the key to creating effective team work and collaborative work environments between nurses and physicians.
2. **Developed collaboratively, involving all stakeholders**. Together payers, employers, and providers should develop shared objectives, measures, and payment methods and seek to minimize the multiplicity of requests and often conflicting requests for information and data. My nursing experience has shown me that the burden of data collection all too frequently falls upon the nursing staff, which in most settings is facing workforce shortages, sicker and more complex patients, and a multitude of other regulatory demands that pull them from direct care duties and time with patients. The evidence is quite clear that more time with patients results in better outcomes.
3. **Used to improve performance**. The use of payment to change incentives in today's healthcare system should reward providers for demonstrating excellence in improving quality and patient safety and providing effective care. To highlight the need the importance of this incentive, I have included a statistical summary of challenges facing the nursing profession that if not remedied will impact the quest for quality and improved performance for our nation's healthcare system at all levels.

The Health Resources and Services Administration (HRSA) projects that, absent aggressive intervention, the supply of nurses in America will fall 36 percent (more than 1 million nurses) below requirements by the year 2020. This report, *what is Behind Horse's Projected Supply, Demand, and Shortages of Registered Nurses?* is available online at: ftp://ftp.hrsa.gov/bhpr/workforce/behindshortage.pdf

The Bureau of Labor Statistics reports that registered nursing will have the greatest growth rate of all US occupations in the time period spanning 2006 – 2016. During this decade, the health care system will require more than 1 million new nurses to meet growing demand and to replace retiring nurses. See: http://www.bls.gov/opub/ooq/2007/fall/art02.pdf

The American Hospital Association surveyed more than 5,000 community hospitals in early 2007. The results of this survey, released in July, 2007, revealed that hospitals across the nation needed 116,000 RNs to fill immediate vacancies. Workforce shortages are reportedly contributing to decreased staff satisfaction, emergency department overcrowding, and decreased patient satisfaction. See "The 2007 State of America's Hospitals" http://www.aha.org/aha/research-and-trends/index.html

The National Commission on Nursing Workforce for Long-Term Care released a report in May, 2005 stating that there are nearly 100,000 vacant nursing positions in long-term care facilities on any given day, and the nurse turnover rate exceeds 50%. The shortage is costing long-term care facilities an estimated $4 billion a year in recruitment and training expenses. See: http://www.ahca.org/research/workforce_rpt_050519.pdf

The lack of young people entering the nursing profession has pushed up the average age of the working nurse. Today, the average age of the RN population is estimated to be 47. See: http://bhpr.hrsa.gov/healthworkforce/reports/rnpopulation/preliminaryfindings.htm

HRSA also projects that, if recent trends continue, the number of RNs leaving the workforce will outpace those entering the profession by 2016. See: http://www.kaisernetwork.org/health_cast/uploaded_files/Nursing_Shortage_Presentation_nesseler_2.pdf

An average vacancy rate of 10.4% for registered nurses and 9.2% for nurse practitioners exists at our nation's 5,000 community health centers. Vacancy rates are even higher in urban areas and small, isolated rural areas. (JAMA 3/1/06)

Impact of the Nursing Shortage on Patient Care:

The nursing shortage is stressing military health care delivery. The Army, Navy, and Air Force are offering new lucrative RN recruitment packages that include large sign-on bonuses, generous scholarships, and loan forgiveness packages. Yet, neither the Army nor the Air Force has met their active service nurse recruitment goals since the 1990s. The Navy has not met its recruitment goal in four years. Army leaders warned the Senate Appropriations Committee on March 7, 2007 that they were experiencing shortfalls of more than 30% in certain key combat specialties (anesthesia and critical care). In 2005, the Navy Nurse Corps recruitment fell 31% below target. Navy Nurse Corps leaders testified in 2007 that "the Navy Nurse reserve component recruitment and retention continues to be of great concern." Air Force Nurse Corp leaders testified in 2007 their 15% shortage was "gravely concerning." See: http://appropriations.senate.gov/hearings.cfm

An Agency for Healthcare Research and Quality (AHRQ) meta-analysis released in March, 2007 showed that every additional full-time nurse per patient day was associated with a 9% reduction in mortality in intensive care patients and a 16% reduction in mortality in surgical patients. In addition, every additional patient per RN shift was associated with a 53% increase in pulmonary failure, a 43% increased risk on unplanned estuation, a 7% increased risk of hospital acquired pneumonia, and a 17% increased risk in other medical complications. http://www.ahrq.gov/downloads/pub/evidence/pdf/nursestaff/nursestaff.pdf

A study based on a review of more than 6 million patients was published in the *New England Journal of Medicine* in May, 2002. The researchers found that nursing shortages were found to correlate with longer lengths of stay, increased incidence of urinary tract infections and upper gastrointestinal bleeding, higher rates of pneumonia, shock and cardiac arrest. Increased hours of RN care resulted in fewer "failure-to-rescue" deaths from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis and deep venous thrombosis. http://content.nejm.org/cgi/content/abstract/346/22/1715

A study published in the January/February 2006 journal *Health Affairs* shows that if hospitals increased RN staffing, more than 6,700 patient deaths and four million inpatient days could be avoided each year. For details, see http://www.nursingworld.org/pressrel/2006/pr0110.htm.

Research published in the October 23, 2002 *Journal of the American Medical Association* demonstrated that more nurses at the bedside could save thousands of patient lives each year. In reviewing the experiences of more than 232,000 surgical patients at 168 hospitals, researchers from the University of Pennsylvania concluded that a patient's overall risk of death rose roughly 7 percent for each additional patient above four on a nurse's workload. Having too few nurses may actually cost more money given the high costs of replacing burnt-out nurses and caring for patients with poor outcomes. http://www.nursing.upenn.edu/news/pdf/PennNursing_JAMA_10-22-02.pdf

In *Health Care at the Crossroads: Strategies for Addressing the Evolving Nursing Crisis*, a report released in August 2002 by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the authors found that a shortage of nurses in America's hospitals is putting patient lives in danger. JCAHO reported that the shortage of nurses contributes to nearly a quarter of all unexpected incidents that kill or injure hospitalized patients.
http://www.jcaho.org/PublicPolicy/nurse_staffing.htm

Current Funding Levels are not Meeting the Need:

In FY 2006, HRSA was forced to turn away 85 percent of the applicants for the Nurse Education Loan Repayment Program (NELRP) due to lack of funding. This means that 3,607 RNs interested in working in facilities deemed to have a critical shortage of nurses were not accepted.

Similarly, in FY 2006, HRSA turned away 96 percent of the applicants for the Nursing Scholarship Program due to lack of adequate funding. This means that more than 6,393 students interested in nursing were turned away from this program last year.

Nursing Education:

The American Association of Colleges of Nursing (AACN) survey data from academic year 2006-2007 showed that nursing colleges and universities denied admission to 42,866 qualified applicants. The data is based on responses from 600 schools which show that enrollment in entry-level baccalaureate nursing programs increased by 7 percent from 2005 to 2006. The top reasons for not accepting applications to entry-level baccalaureate programs included insufficient faculty (71%), and admission seats filled (74%).

The National League for Nursing (NLN) released a preliminary report on December 9, 2005 which estimated that schools of nursing with entry-level baccalaureate, associate, and diploma programs were forced to reject more than 147,000 qualified applicants for 2005. This was an 18 percent increase over the previous year's figures. www.nln.org

The NLN reported in July, 2006 that there were 1,390 budgeted, unfilled, full-time nursing faculty positions nationwide in 2006. This represents a 7.9 percent vacancy rate in baccalaureate and higher degree programs, an increase of 32 percent since 2002; and a 5.6 percent vacancy rate in associate degree programs, an increase of 10 percent in the same period. See:
http://www.nln.org/newsreleases/nurseeducators2006.htm

4. **Use positive and not negative incentives**. Incentive approaches to payment should use a system of rewards to increase payments or reduce regulatory burdens for successful providers. Because government Medicare and Medicaid reimbursement as well as many private insurers already pay less than the cost of care, incentives involving penalties should not be used. Often the burden of unfunded regulations falls heavily on nurses at the bedside, so rewards that decrease regulatory burden for successful providers would directly impact those bedside nurses.
5. **Provide meaningful reward amounts**. Rewards provided through incentive-based approaches should be significant enough to motivate change in the behaviors of those who would receive them.

Because the growing body of evidence linking hospital nursing workforce to patient outcomes, one way to improve quality is to increase nurse staffing. This evidence is supported by researchers such as Aiken, Buerhaus, Needleman and others. This is not an inexpensive solution as nursing accounts for nearly 40 percent of hospital costs in research reported by Dalton.

AONE is also in agreement with AHA that in developing performance measures it is critical to

1. **Define performance based on improving quality**.
2. **Reward based on evidence-based measures of adherences to quality improvement processes.**
3. **Use measures that accurately recognize differences among hospitals and the patients they serve.**
4. **Ensure that any performance measures used are updated regularly to accommodate changing treatment protocols**.
5. **Selected to minimize data collection burden for providers.**

Nursing and the Quest for Quality

In the view of AONE, and supported by the literature, nursing is a key partner in attaining and sustaining quality outcomes in our healthcare facilities. The steadily increasing acuity of hospitalized patients and the ability to adequately staff to meet the growing demands for care are all part of the complex equation of value-based purchasing. It should be noted that since the inception of the Diagnostic Related Groups (DRGS), nursing has been treated as a fixed cost. It is our hope that as CMS financing moves to value-based purchasing, nursing care and the intensity of the care provided to individual patients will be examined to shed light on the importance of nursing as a resource to achieving quality and the impact of that care on individual hospitalized patients. AONE is currently supporting research on incorporating nursing intensity into the DRG system. We hope that this research will provide some preliminary answers of how to capture the intensity of nursing care and the impact on quality. We welcome the opportunity to share it with the Committee at an appropriate time.

As the healthcare industry strives to ensure patient safety at every level of care, the role of nursing and the nursing care that is provided have taken on critical importance.

Thank you Mr. Chairman. I am happy to take your questions.