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Nursing's Ethical Responsibilities in Value-Based Purchasing

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Since publishing *To Err Is Human* (2000), the Institute of Medicine (IOM) has pushed for improvement in workforce environments, patient outcomes, and patient safety (Institute of Medicine [IOM]). *To Err Is Human* (2000) focused on medication errors, while *Crossing the Quality Chasm* (2001) examined safety, effectiveness, patient-centeredness, efficiency, equitableness, and timeliness (IOM). In 2004, the IOM published *Keeping Patient's Safe: Transforming the Work Environment of Nurses* which explored the relationship between nursing practice environment and patient safety. Bringing these issues to public attention resulted in calls for healthcare reform among many stakeholders.

One healthcare reform revolves around patient-centered care. Patient-centeredness has gained momentum with consumers and stakeholders, especially with the arrival of pay for performance (P4P) initiatives (Centers for Medicare & Medicaid Services [CMS], 2007). These P4P initiatives (more recently referred to as value based purchasing [VBP]) were instituted in 2013 (Moody-Williams, 2012). This program was brought about due to increased healthcare costs, high rates of adverse events, increased readmission rates and a perceived decrease in quality of care provided (Moody-Williams, 2012).

The goals of the VBP program are to effectively lower healthcare costs while improving patient outcomes (Moody-Williams, 2012). The reimbursement initiatives outlined by CMS in the *Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program* (2007) has a relationship with nurses practicing in acute care facilities. While one purpose of this article is to inform the reader of relationships between the practice environment and VBP, the primary purpose is to guide the reader in gaining an understanding of the ethics involved in the relationship between nursing practice and VBP.

Background

Nursing practice environment. Examining the nursing practice environment begins with defining nursing. The American Nurses Association states, "Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (Nursing World, 2012, p. 1). The nursing practice environment in the acute care setting is defined as "the organizational characteristics of a work setting that facilitate or constrain professional nursing practice" (Lake, 2002, p. 178). Ditomassi (2012) states, "A professional work environment for nurses, particularly in the inpatient setting, is recognized for the relationship with staff retention, good patient outcomes, and safe patient care" (p. 266). Common themes throughout these definitions are protection, promotion, prevention, facilitation, constraint, good outcomes, and safe care.

The literature has identified relationships between negative practice environments and increased mortality, increased failure to rescue, and increased adverse events (Aiken et al., 2008; Brooks-Carthon et al., 2011; Friese et al., 2008). Conversely, positive practice environments demonstrated decreased odds of death and decreased incidents of failure to rescue (Aiken, Cimiotti, et al., 2011). Associations were identified between positive practice environments and decreased central line acquired blood-stream infection (CLABSI) rates, decreased hospital acquired conditions (HAC), and decreased fall rates (Chan et al., 2011; Kelly et al., 2013; Thompson et al., 2013). Several articles identified relationships between the practice environment and nurse perception of the quality of care provided to patients (Aiken, Sloane et al., 2011; Djukic et al., 2013; Eaton-Spiva et al., 2010; Friese, 2005; Kim et al., 2009; Kutney-Lee, Lake et al., 2009; Laschinger, 2008; Patrician et al., 2010). Recent research has begun to demonstrate associations between the practice environment and patient satisfaction with care (Aiken et al.,

2012; Boev, 2012; Brooks-Carthon et al., 2011; Kutney-Lee, McHugh et al., 2009; McHugh et al., 2011).

Value based purchasing. Funding for VBP will be provided by reducing the amount of reimbursement hospitals receive on Diagnosis-Related Group (DRG) payments (Moody-Williams, 2012). In 2013 the amount of DRG reimbursement was reduced by 1% with an incremental increase each year until the maximum of 2% reduction is reached in 2017 (Moody-Williams, 2012). Hospitals involved in the VBP program are those acute care facilities that have met the requirements established by CMS (Moody-Williams, 2012). Reimbursement in fiscal year 2013 (FY2013) centered on 12 Clinical Process of Care Domains (70% of reimbursement) and eight Patient Experiences of Care Domains (30% of reimbursement) (Quality Net, n.d.). The Patient Experiences of Care Domains are measured through the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey (Moody-Williams, 2012).

The VBP requirements beginning in 2013 will change each year in that requirements will build on previous years. For example, beginning FY2015 all domains from previous years (12 Clinical Processes of Care Domains, Patient Experience of Care Domain, and Outcome Domains) will be evaluated for reimbursement in addition to two new requirements added to the Outcome Domain and a fourth Efficiency Domain (Quality Net, n.d.). Hospitals must have a set number of cases or surveys in order to be eligible for reimbursement.

Discussion

To understand the relationship between nursing practice and VBP, one must first understand how performance initiatives are applied to healthcare organizations. Butts and Rich (2008) discuss the importance of organizations having ethics programs that work with compliance programs, such as VBP, to improve patient outcomes. The authors state, "Ethically, the principles of autonomy, beneficence, nonmaleficence, and justice are at risk for violation in relation to

patients, health care professionals, and the general public," when compliance is not adhered to ethically by the organization (Butts & Rich, 2008, p. 126).

The American Nurses Association (ANA) Code of Ethics guides nursing practice in the United States (American Nurses Association [ANA], 2001). Of the nine provisions, Provisions one, two, and three directly relate to the ethical considerations for the reimbursement initiatives of VBP. Provision one calls for nurses to practice "with compassion and respect for the inherent dignity, worth and uniqueness of every individual…" (ANA, 2001, p. 1). Provision two emphatically states, "The nurse's primary commitment is to the patient" (ANA, 2001, p. 1). Provision three addresses "promotes, advocates for, and strives to protect the…rights" (ANA, 2001, p. 1).

In 2010, ANA revised their position statement regarding the nurse's role in ethics and human rights (American Nurses Association [ANA], 2010). Many of the 18 recommendations in this revised statement are relevant to VBP; however, two of the recommendations stand out: "Nurses advocate for the ethical and just practice of nursing by creating and sustaining environments that support accepted standards of professional practice...Nurses strengthen practice environments by refusing to practice in ways that would create a negative impact on the quality of care." (ANA, 2010, p. 7). The following discussion will provide details regarding each of the four domains included in the VBP program and an exploration of ethical considerations in relationship to nursing practice for each of the domains, where applicable.

Clinical process of care domain.

For FY2015, the following reflects 12 measures hospitals are accountable for meeting:

- Acute myocardial infarction
    - "Fibrinolytic therapy received within 30 minutes of hospital arrival
    - Primary PCI received within 90 minutes of hospital arrival." (Quality Net, n.d., p. 1).

- Heart failure
    - "Discharge instructions" (Quality Net, n.d., p. 1).
- Pneumonia
    - "Blood Cultures performed in the Emergency Department prior to initial antibiotic received in hospital
    - Initial antibiotic selection for CAP in immunocompetent patient" (Quality Net, n.d., p. 1).
- Surgical Care Improvement Project
    - "Surgery patients on a Beta Blocker prior to arrival that received a Beta Blocker during the perioperative period
    - Prophylactic antibiotic received within one hour prior to surgical incision
    - Prophylactic antibiotic selection for surgical patients
    - Prophylactic antibiotics discontinued within 24 hours after surgery end time
    - Cardiac surgery patients with controlled 6 a.m. postoperative serum glucose
    - Postoperative urinary catheter removal on postoperative day 1 or 2
    - Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery" (Quality Net, n.d., p. 1).

Reimbursement centers on whether or not hospitals have at least ten cases for four of the 12 Clinical Processes of Care Domains (CMS, 2013).

Examining these 12 care processes demonstrates the ethical consideration of beneficence and nonmaleficence. Beneficence is "people take actions to benefit and to promote the welfare of other people" (Burns & Grove, 2009, p. 47). In the Belmont Report, "beneficence is understood in a stronger sense, as an obligation" (Belmont Report, 2003, p. 34). Along with beneficence is the standard of nonmaleficence "to do no harm" (Butts & Rich, 2008, p. 44). Each of these care

processes involves nurse participation. For example, a patient presenting with an acute myocardial infarction must first see an admissions nurse. In order for the physician to prescribe fibrinolytic therapy, a nurse must first advocate for the patient to be a priority admission. Discharge instructions for the heart failure patient are an additional responsibility of the nurse.

Administration of medications is a nursing task. While obtaining blood cultures could be delegated to a laboratory technician, it is a nurse who should ensure that antibiotics are not administered before any cultures are obtained. Nurses understand the importance of obtaining the best data to achieve optimal outcomes for patients. While a bedside nurse might not prescribe the antibiotic for a patient with CAP, they are the individuals obtaining admission data for input into the electronic health record. As they obtain the health history, nurses are understanding relationships between symptoms and history; thereby recognizing the need to communicate with physicians about potential CAP in the immunocompetent patient.

In regards to surgical care improvement project, ensuring that patients receive the Beta Blocker during their perioperative period falls under nursing responsibility. This is the same for administering the prophylactic antibiotic the hour before surgery or ensuring the blood glucose is controlled before cardiac surgery. Also, advocating for discontinuation of antibiotics or removal of catheters at an appropriate time is an obligation of the nurse assigned to that patient. Nurses receive an education that emphasizes clinical reasoning, of which many of these care processes require. In truth, while CMS chooses to mandate these care processes, the authors would suggest that the care processes are an ethical obligation of the professional nurse irrespective of government compliance requirements. What professional nurse would not want to facilitate best practice by providing appropriate, effective care for a patient?

Patient experience of care domain.

The patient experience of care is determined by a patient satisfaction survey known as the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS) (CMS,

2012, July). This survey is a 32 item tool that measures eight dimensions: "Communication with nurses, communication with doctors, and responsiveness of hospital staff, pain management, and communication about medicines, cleanliness and quietness of hospital environment, discharge information, and overall rating of hospital" (CMS, 2012, July).

For the first six domains, only "always" on the four-point Likert tool is accepted for reimbursement purposes (CMS, 2012, July). For the domain regarding discharge information, a yes/no response is required (CMS, 2012, July). Overall rating of hospital is measured on a 1-10 scale, with one being not likely at all to recommend and ten being very likely to recommend (CMS, 2012, July). Under the VBP program, only those respondents who select 9 or 10 are counted for reimbursement purposes (CMS, 2012, July).

Respect for persons is associated with the ethical standard of autonomy. Autonomy is defined as "the freedom and ability to act in a self-determined manner" (Butts & Rich, 2008, p. 42). Patient autonomy is threatened when a healthcare organization does not meet the patient needs. Just as in the clinical care processes, many of the patient experience of care domain contain questions that relate to the professional nurse. For example, pain management, communication about medications, discharge instructions, responsiveness of staff, and quietness of hospital environment involve aspects controlled or performed by nurses. Although not all of the responses can receive a rating of "Always" from the patient, the authors contend that based on Provision one and Provision two of the ANA code of ethics, the professional nurse has a moral obligation to ensure that communication is exceptional, pain is controlled, medications are explained, discharge instructions are communicated effectively and staff responds to patient needs.

Outcome domain.

The outcome domain involves examining the 30 day mortality rates for acute myocardial infarction, heart failure, and pneumonia (Quality Net, n.d.). For FY2015, CLABSI and the

Agency for Healthcare Research and Quality's patient safety indicators (PSI) have been added (CMS, 2013). These PSI measurements include

- "Pressure Ulcer Rate,
- Iatrogenic Pneumothorax Rate,
- Central Venous Catheter-Related Bloodstream Infection Rate,
- Postoperative Hip Fracture Rate,
- Postoperative Pulmonary Embolism or Deep Vein Thrombosis Rate,
- Postoperative Sepsis Rate,
- Postoperative Wound Dehiscence Rate, and
- Accidental Puncture or Laceration Rate" (CMS, 2013, p. 13).

Mortality outcomes are measured only if the hospital has 25 or more patients in each category (CMS, 2013). Patient safety indicators are determined if there are at least three patients in one of the indicators (CMS, 2013). CLABSIs are counted if one case is determined (CMS, 2013). Finally, hospitals are examined overall in this domain and must have at least two of the five measures within the designated time period (CMS, 2013). A fourth domain, Efficiency Domain, examines Medicare spending for each beneficiary (Quality Net, n.d.). The goal with this domain is to determine if hospitals used the least amount of money to provide quality care (CMS, 2013).

As with the first two domains, the additions to FY2015 reflect areas in which nursing is intimately involved. For example, while physicians/advanced practice nurses are responsible for insertion of the central venous catheter (CVC), all other care related to the CVC is performed by the professional nurse. It is a moral and ethical obligation of the professional nurse to ensure the standard of care by following evidence-based practice when managing the CVC. This is also true for preventing pressure ulcers, DVTs, sepsis, and falls. Although the physician or advanced

practice nurse may initiate orders regarding care, it is the professional nurse who will ensure related care is carried out appropriately.

Summary

Healthcare reform is continuously evolving. One reformation is the VBP program for the purpose of decreasing adverse events, decreasing readmission rates, decreasing cost of care, improving quality of care, and improving perception of care. Research has demonstrated that there are associations between the nursing practice environment and the items being evaluated by VBP. In the context of the nursing practice environment, those aspects of the VBP domains related to nursing should be performed by professional nurses under the context that it is a moral and ethical responsibility of the nurse to provide optimal care to the patient as outlined by the ANA Code of Ethics.

The organization in which the professional nurse is employed plays a significant role in providing an environment in which the nurse meets the ethical standards of the profession. Although organizations use compliance programs as an ethical guide to provide care, this is not the platform for success as an organization (Butts & Rich, 2008). Strong ethical leadership within an organization provides for ethical communication, quality and collaboration that allow all members of the healthcare team to meet the needs of patients and other members of the team (Butts & Rich, 2008). When this occurs, compliance mandates are surpassed for that organization, leading to increased reimbursement which is a win/win for all.

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