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Challenges and Directions for Nursing in the Pay-for-Performance Movement

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Abstract

Pay-for-performance (P4P) initiatives attempt to drive quality of care by aligning desired care processes and outcomes with reimbursement. P4P schemes have emerged at a time of great concern about safety and quality in health care and in the face of a growing nurse shortage. This article discusses the state of the literature linking structures for providing nursing care, measures of process heavily favored in P4P initiatives, and patient outcomes and outlines how P4P is expected to affect nursing practice. It also presents directions for managing practice settings to cope with P4P and for steering nursing's involvement in this area of health policy. As implementation broadens, it remains to be seen whether unintended consequences emerge or whether nurses are successful in using the programs and the data sets that result from them to justify investments in nursing services and solidify the profession's position.

Keywords

pay for performance; P4P; nurse staffing; nurse practice environments; quality improvement

A relatively recent development in the past decade of high-intensity policy activity related to health care safety and quality in the United States has been the emergence of pay-for-performance (P4P) initiatives. P4P, as the name suggests, attempts to drive improvements in quality of care by aligning desired care processes or outcomes with reimbursement. In some ways, these programs are close cousins of the standards-based movement in elementary and secondary education in many states that have been institutionalized in the federal No Child Left Behind (NCLB, 2001) legislation. NCLB ties school, school district, and state education funding to student performance on standardized tests. Like NCLB, P4P is an effort to introduce a new level of accountability among managers in a costly, complex system where variable service quality and even wider variations in outcomes among service recipients are seen. Also like the education schemes, in practice, P4P programs generally cut payments to underperforming service providers rather than recognize high quality performance *per se*.

P4P has entered the nursing landscape, particularly the acute care setting (where slightly more than half of registered nurses still work) at a time of unprecedented concern about the safety

and quality of health care shared with other stakeholders, including health care managers and executives, patients and their families, payers, and policymakers. There are also concerns about whether or not there are sufficient numbers of nurses to provide care now and in the future, and many observers question whether health care facilities and the health care system as a whole can afford optimal levels of highly trained nurses. Although the extent to which P4P will affect clinical and financial performance of individual health care organizations or the United States health care system as a whole is largely unknown, its impacts on nursing services are even less clear, especially given current and future turbulence in the nurse labor market. Nonetheless, health care opinion leaders are united in their belief that because P4P is not a passing fad, it merits serious attention. This article attempts to trace the challenges and opportunities for the practice of nursing, the administration of nursing services, and nursing's role in health policy that have been created by P4P.

Nursing Outcomes Research and Determinants of the Quality of Nursing Care

Only in the last decade has an evidence-based understanding of how nursing factors influence patient outcomes begun to take shape. Nonetheless, a body of findings regarding properties of organizations correlated with nursing-related outcomes in acute care has accumulated rapidly, and is gaining momentum in other sectors such as long-term care.

To provide safe care, let alone care of excellent quality, a critical mass of staff is required to actually perform various care acts. However, staff must also have the requisite knowledge to provide care competently, and the organizational context must provide nursing personnel with necessary tools and resources to provide care (including support services), allow them to exercise judgment on behalf of patients with the support of their managers, and collaborate with other workers and professionals (Clarke, 2007; Lake, 2007). A critical mass of studies, conducted mainly in acute care settings, shows that adverse outcomes are higher in the presence of lower staff-to-patient ratios (Kane, Shamliyan, Mueller, Duval, & Wilt, 2007) and in situations where staff educational preparation is lower (Clarke, 2007). Overall, staffing-outcomes research suggests (as common sense would support), that a minimal number of properly prepared workers are a necessary, but not sufficient, condition for good care and that (at least within most commonly observed levels) higher staffing levels have incremental effects on improving quality of care (Clarke, 2005). This literature is sparser regarding the exact nature of practice conditions other than staffing that affect outcomes, the processes of nursing care affected by organizational conditions, and outcomes and processes of care in settings other than inpatient care (although a literature has accumulated regarding staffing parameters in long-term care). Limitations in data sources for nursing and patient outcomes variables have led to stalling regarding the best ways to optimize outcomes of nursing care with finite, if not scarce, resources. Nurse managers and executives use a combination of tradition, on-the-ground observations and judgment, and cost tracking to determine whether staffing is adequate or if the environment for practice in place is facilitating sound care (Clarke, 2007).

Research and practice in outcomes management have provided at least two lessons about measuring quality of care and interpreting outcomes indicators. The first is that although there are situations or outcomes that should truly never arise because they represent such serious failures of systems of care (for instance, administering a medication to a patient with a documented allergy to it), in great measure, how patients fare is affected by a matrix of factors that include not only the characteristics of patients' health care providers and the providers' actions, but also patient characteristics. Therefore, arriving at definitions of numerators and denominators for computing meaningful outcomes rates require a close understanding of patient and patient care context. The second lesson relates to the critical role of consistency in data collection. As managers and quality professionals in health care facilities are well aware, collecting reliable, consistent data about indicators is more easily said than done. This is

certainly the case in nursing, although the preliminary set of nursing-sensitive measures issued by the National Quality Forum (NQF, 2004) is certainly a step in the right direction. However, application of these measures remains a voluntary pursuit and archiving many of the measures in NQF's data sources for use by payers, the public, or for researchers is a distant goal. Without a clear set of mechanisms and motivators for promoting widespread use of a set of common indicators, measure development will have limited impact.

How and Where P4P is Likely to Influence Nurses in the United States

Major health care payers, from the Medicare program, to private insurers, intend for P4P to assist them in becoming more effective and value-based purchasers. Their hope is to use their control over reimbursements to link payment to the quality of services and thereby improve quality of care and outcomes for their beneficiaries by reducing unnecessary inconsistencies in care across providers, all the while controlling expenditures (Davis & Guterman, 2007).

Currently, most P4P programs involve "pay for reporting" (i.e., added reimbursement for contributing performance data to a centralized repository). Often there is a public reporting component tagged on to these initiatives that is meant to enhance consumer information and provide added incentives to improve the aspects of care being tracked. The highest level of P4P directly ties payment to indicators and indeed there has been a flurry of pilot or demonstration projects where various payers, including the federal Medicare program, offer the potential for increased payments to the "high performers" among a small group of practices or provider agencies on a set of measures (Rosenthal, Landon, Normand, Frank, & Epstein, 2006). These pilot projects are intended to work out logistical details, challenges, and impacts in anticipation of wider roll out of the programs.

One initiative destined to affect many nurses is the pay for reporting scheme (destined to become a P4P initiative) for acute care hospitals treating adult medical and surgical patients that was embedded in the Medicare Modernization Act (2003). The Centers for Medicare & Medicaid Services (CMS) along with many national interest groups developed a hospital quality initiative involving incentive payments for hospitals that submit measures to a national data repository (CMS, 2005). Beginning several years ago, full Medicare reimbursement for nearly all facilities became contingent on acute care hospitals contributing data regarding the specific aspects of care provided to targeted patient groups to a national repository. Currently 20 aspects of care are measured, dealing with evidence-based care practices vetted by experts as having scientifically based connections to patient outcomes. Measures collected by institutions using carefully outlined protocols ensure reliability (see www.hospitalcompare.hhs.gov and related sites). After archiving and cleaning, the data are presented through a CMS Web site in customized reports for consumers and as a complete dataset for researchers and others to analyze beginning in 2005–2006 for 2004 data. The measures include 8 aspects of care for acute myocardial infarction, 4 for heart failure, 6 for pneumonia, and 2 for the prevention of surgical wound infections. They involve timely administration of medications and treatments, key assessments, and patient counseling (especially smoking cessation) that nurses are involved in either coordinating or implementing.

A great deal of attention is being focused on these measures by researchers and scholars, in terms of their reliability (their consistency within institutions over time periods when they ought to be stable), their validity (whether they address elements germane to stakeholders, or merely measure, for instance, case mix), and their sensitivity to change, and the organizational and provider factors that appear to be tied to them. Examining 2004 data, Landon and colleagues found, for instance, that patients admitted with a variety of medical conditions (including acute myocardial infarction and pneumonia and chronic lung and heart disease) were more likely to have documentation in their charts that would meet key process of care

quality criteria when registered nurse hours of care per patient day were higher and licensed practical nurse hours of care per patient day were lower (Landon et al., 2006). A study currently in progress at the University of Pennsylvania's Center for Health Outcomes and Policy Research, funded by the Robert Wood Johnson Foundation's Interdisciplinary Nursing Quality Research Initiative (S. Clarke, PI, 2006 to 2008) will further examine nursing-related organizational correlates of the Hospital Compare measures. Results, and in particular, findings related to the sensitivity of these measures to nursing-related factors, are expected to have important implications for managers and executives, and for the development of the further development of P4P schemes.

The Hospital Compare measures are process-of-care indicators—they address the proportion of patients who should be receiving certain treatments who actually receive those treatments. Patients, families, and other nonclinician stakeholders are generally somewhat more interested in how patients fare than about the details of clinical care. A variety of endpoints—clinical events or downstream impacts of clinical care, such as mortality and complication rates—are also being studied and introduced in public reporting schemes with an eye to eventual inclusion in more formal P4P initiatives. However, one recent development has been the emergence of a CMS policy that will discontinue payment for the treatment of complications deemed preventable beginning in October 2008 (Rosenthal, 2007). Some of these, (for instance, objects left in patient during surgery, air embolism, and blood incompatibility) would seem to clearly reflect errors on the part of a particular group of providers. Other conditions that will no longer receive coverage for treatment if they develop while a patient is in the hospital include pressure ulcers, catheter-associated urinary tract infections, vascular-catheter bloodstream infections, and falls from bed. It is presumably possible to eliminate all of the incidents in the first group, and most (but perhaps not all) of those in the second through rigorous adherence to safe practices and meticulous preventive care. Although many anticipate that quality improvement efforts will be jumpstarted by this policy move, others are fearful that financially troubled hospitals treating large numbers of vulnerable patients will be endangered, and that hospitals in general will have a disincentive for admitting at-risk patients and will steer excessive resources toward exhaustive admissions assessments to ensure that they are not held financially accountable for conditions that are “not their fault.” Both the operational details of the policy and its impact remain to be seen.

Many nurses are employed in outpatient and community settings and in long-term care facilities, where further P4P initiatives address aspects of care in which nurses play a role. Nurses also work in advanced practice roles and may well be providing screening, prescribing medications, and overseeing long-term treatment for clienteles that have been targeted by P4P efforts, including high-volume and high-cost populations, such as adult diabetics, and patients with congestive heart failure and coronary artery disease. Tax relief has been proposed for physicians in outpatient and inpatient care (but not yet for nurses or advanced practice nurses) who participate in voluntary reporting of processes of care for patients in their practices (Johnson, Harper, Hanson, & Dawson, 2007). In a press release dated October 11, 2007, CMS announced plans for a 2-year home health P4P demonstration project to begin in January 2008 in seven states.

Although P4P initiatives are moving across sectors of the health care system and the continuum of care, a number of issues remain contentious. Debate still surrounds the selection of measures. The stakes are high and many groups, from trade associations in the health care industry, to professional organizations and associations and health services researchers, are involved in regular discussions about the most suitable measures for use in P4P. Recurrent questions relate to whether specific measures have clearly articulated definitions that permit comparison across providers and which are resistant to “gaming” and detection bias. Gaming refers to patient selection, classification, and coding practices that have artificially favorable ratings on

indicators. When detection bias exists higher quality providers may look worse than others, not because of lower quality of care, but because greater awareness and conscientiousness of clinicians and better documentation of findings can lead to higher rates of recorded complications.

Indicators will likely change as evidence supporting or disconfirming the validity of different measures and treatment approaches accumulates. Much like the practice guidelines they are often based on, indicators can reflect the stakes and biases of the various stakeholders (including practice habits, industry pressures, and researchers' programs of funded studies). Extensive efforts under the auspices of the NQF and other groups are generating short lists of valid, reliable, research-based measures that are relevant to clinicians, payers, and patients, but this work is very challenging (Kurtzman & Corrigan, 2007). In view of the potential impact of P4P on health care organizations' reimbursements and reputations, nurses in all sectors should help to develop and shape P4P rather than wait to react to its consequences.

Debate continues around the precise ways P4P programs should be designed to maximize their benefits to patients and the health care system. For instance, in addition to selecting the right measures, questions remain regarding the proportion of reimbursement that should be at stake to constitute adequate inducement for improvement, the extent to which only the "best" providers should be recognized and rewarded. Some have also asked whether the quality of care for underserved and vulnerable populations can or should be targeted by P4P schemes (Rosenthal & Dudley, 2007).

Initiatives to develop consensus measures continue and public reporting (with or without financial incentives for doing so) is increasing. Formal P4P is destined to become more widespread and will likely involve increasing movement from pilot programs that shift a portion of the payments for core services into a pool for superior performers toward more formal and larger-scale programs.

So Where Does Nursing Fit in P4P?

Nursing care is central to preventing poor outcomes and ensuring optimal outcomes in many different sectors of the health care system. Empirical evidence suggests that patients in institutions that have made more investment in nursing care (in terms of staffing levels or nurse education) have fewer adverse events (Clarke & Donaldson, 2008; Kane et al., 2007; Unruh, 2008). However, the connection between nursing care or the resources for providing it and "hard" patient outcomes or the "bottom line" in health care facilities is relatively weak in the minds of many. Today, leaders invest in staffing levels, staff education, and work environments primarily on faith (rather than concrete data). They rely mainly on instincts rather than research findings to conclude that better or enriched working conditions will ultimately reduce expenditures per patient relative to reimbursements (including avoidable prolongations in hospital stays that may not be fully reimbursed and medicolegal liability for errors in care and poor outcomes), control human resource costs, and have salutatory effects on a facility's reputation in the community.

If nursing factors are linked with the process and/or outcome indicators involved in P4P—as common sense and early evidence suggest they might be—then, given nurses' close contact with patients in acute care and central role in patient flow, P4P initiatives may provide an entirely new line of arguments for investments in nursing services and structures (the so-called "business case"). P4P initiatives may also drive the creation of new sources of well-collected nursing-sensitive process data. This may yield a number of benefits because process of care may be an area where well-managed nursing services shine. Eventually, reporting, archiving, and reimbursement provisions of P4P at the national level may encompass nursing-sensitive outcomes data beyond medical treatments and mortality rates as well.

Leaders in health care facilities across the country are quickly attempting to figure out how to maximize their reimbursements under P4P. It seems clear that ensuring that certain key evaluations and treatments are performed and documented will demand that basic elements of high-quality nurse practice settings be present. P4P initiatives may serve as an additional springboard for discussions about nursing services in a health care facility as a resource for meeting performance targets (rather than exclusively as a cost center). The need for systems redesign for many institutions to keep up with P4P and other regulatory imperatives may also highlight the special placement of nursing in institutions. Nurses with special training in systems functioning and analysis and organizational change (typically taught in graduate leadership and administration programs) may play pivotal roles in diagnosing problems with processes and implementing solutions to achieve optimal quality of care as measured by P4P indicators.

The Hope and the Danger

The intent of P4P schemes is, of course, that financial inducements will cause individual providers (assisted by their facilities' leaders and institutional resources) to change their practice in meaningful ways and that both measured and unmeasured indicators and patient outcome endpoints will improve. Overall, the hope is that P4P will stimulate and reinforce new, better care practices.

However, there are at least two ways this could go astray. The first is that institutions will focus wholly or almost wholly on specific indicators targeted by the schemes rather than broader issues in safety and quality of care or on how patients actually fare. The fear is that clinicians and managers will "teach to the test" (to use a metaphor from the NCLB critiques)—that is, that they will focus on efforts to improve scores without necessarily improving broader aspects of care or the end outcomes that the measures try to address). Some fear that unintended (and perhaps even perverse) consequences will result, particularly because there are doubts as to whether or not currently used performance measures are true indicators of the quality of care or predictors of outcomes. Werner and Bradlow (2006), among others, have produced data showing slim correlations between CMS process of care indicators and risk-adjustment mortality rates in hospitals. Other authors have suggested that a focus on specific processes of care may lead to heightened attention to those and only those elements and lead to neglect of important unmonitored aspects of care. The end result may be a neutral or even negative impact on patient outcomes.

A second possibility, equally distressing, is that institutions with limited resources may find themselves in a downward spiral of producing poor outcomes and having minimal resources to improve the underlying performance or the documentation of their work to fulfill regulatory mandates, leading to lower reimbursement and even fewer resources and so forth. Thus, P4P could indirectly feed widening gaps in care quality among facilities.

Another potential unintended consequence of P4P shared with other initiatives in the quality-outcomes movement, is its potential negative impacts on nursing workload through worsening documentation burden. Many estimates place the proportion of acute care nurses' time spent in documentation at 30% or more of nurses' workdays (and even higher proportions of time in home health and some other arenas; American Hospital Association, 2003; Page, 2004). The challenges in aligning documentation, either from the Electronic Medical Record or in paper charts, with P4P imperatives (to make sure, for instance, that aspects of care that "count" for reimbursement are always present when relevant) must be considered alongside their demands on nurses' time and attention, especially as P4P programs grow in scope and sophistication.

The burdens on not only clinicians, but the entire nursing service and the many clinical and support departments, of carrying out quality monitoring, tracking indicators, and maintaining

their quality are potentially quite serious as well. There could be a significant diversion of effort from clinical care and its improvement, toward ensuring accurate data collection for use by payers to place a health care organization in the most favorable light possible. The proliferation of programs and indicator lists are forcing some acute care facilities to track literally hundreds of indicators simultaneously.

Although some pilot data have shown modest improvements in performance associated with participation in P4P initiatives (e.g., Grossbart, 2006; Lindenauer et al., 2007), the research literature has very little to say about whether or not P4P schemes have their intended impacts on quality or whether they produce unintended consequences (Petersen, Woodard, Urech, Daw, & Sookanan, 2006). Nevertheless, P4P appears to resonate with the current ethos in government and in some circles in health care and seems destined to be a feature of the landscape. Therefore, nurses must learn as much as possible about the schemes and the factors affecting the measures that will be used in the schemes to participate in preparations in their practice agencies and to play a meaningful role in influencing policy.

Preparing the Organization of Nursing Services to Respond Successfully to P4P: Lessons From Home Health

Beyond having a critical mass of staff on hand to provide the services whose processes or outcomes will be monitored by P4P schemes, a number of organizational elements will help health care organizations deal with current and future demands created by P4P. Here, we give some examples of these elements found at the Visiting Nurse Service of New York (VNSNY).

VNSNY is the largest not-for-profit home health agency in the United States. It employs more than 12,000 clinical, paraprofessional, support, and administrative staff. On any given day, VNSNY has an estimated 31,000 patients in its care in the five boroughs of New York City and Nassau and Westchester counties.

Home health care is distinct from acute care in several important respects beyond the obvious difference in care delivery setting. These differences include the centrality of nurse-delivered care to its mission; the goal of helping patients remain at home and in their communities for as long as possible; the ability to provide assistance to those with long-term care needs; and the greater likelihood that family caregivers will be included as part of the care team. VNSNY has learned in practice four ingredients are critical to its ability to be prepared for a future of P4P: a well-developed information technology infrastructure; a performance measurement system; mechanisms for practice improvement and continuous quality improvement; and research capacity. Although providers such as the Veterans Administration have had such tools in place for some time, home health agencies have had to innovate to adapt and adopt these tools within the context of a highly decentralized workforce, for patients who see many providers across many settings. This decentralization may very well be a trend that continues across settings in the future, as the aging population grows, as public funding for health care continues to shrink, and as states look to shift spending toward less expensive home-and community-based options.

Since October 2000, Medicare-certified home health care providers have been required, as a condition of participation, to collect and submit the Outcome and Assessment Information Set (OASIS). The OASIS is a group of data elements that represent the core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI). The 12 OBQI measures include three indicators related to improvement in getting around; four measures related to meeting the patient's activities of daily living; two measures at the conclusion of the home care episode about whether the patient is able to remain at home and whether surgical

wounds have improved or healed; and three measures related to patient medical emergencies. Agency performance on OBQI measures are publicly reported on CMS' "Home Health Compare" website—analogue to the "Hospital Compare" Web site—allowing consumers to compare home health providers on quality.

In addition, third-party payers such as managed care companies are requiring increasingly complex and frequent patient reports to monitor and assess utilization levels and authorize ongoing services. Establishing systems for such reporting can be a costly endeavor, especially when managed care payers often already reimburse providers at a discounted rate.

Investing in Information Technology

In response to regulatory and payer pressures to collect and report on patient sociodemographic, medical, plan of care, and outcomes data, VNSNY has made significant investments in technology. These include mobile notebook computers for clinicians equipped to allow nurses to securely create and access a structured patient electronic health record in the field, during the provision of care. This record includes demographic characteristics, medication and health histories, laboratory test results, and progress notes. The integration of computerized health records into hospital-, clinic-, and office-based care settings has been less critical and therefore, somewhat slower, despite the rapid adoption of computerized billing into health care many years ago. P4P initiatives will likely serve as a catalyst for better IT infrastructure in these settings in the future.

The second ingredient required for health care providers in all settings to prepare for P4P is a performance measurement system to transform selected data collected at the point of care into indicators to ensure regulatory compliance and to self-monitor quality of care. At VNSNY, indicators tracked in its performance management system include process measures (such as documentation of care management efforts); outcomes (such as potentially avoidable hospitalizations and improvements in a patient's ability to perform activities of daily living); utilization measures (professional and paraprofessional utilization per episode of care); and patient satisfaction (with care and with interactions with the central office). Clinical managers generate updated scorecards with these indicators on a monthly basis for review with the clinicians and paraprofessionals on their teams. These scorecards are also reviewed by cross-agency senior and executive management on a quarterly basis.

The third critical ingredient to prepare for P4P is to have mechanisms for practice improvement. Regardless of the care setting, providers must be able to understand factors underlying performance issues and rapidly implement improvements to face P4P. Many organizations have interdisciplinary teams that identify and disseminate best practices, provide continuing clinical education, and when appropriate, standardize care practices to improve quality of care. VNSNY has created Centers of Excellence, staffed by clinical nurse specialists who provide expert consultation to VNSNY clinicians in the field for specific acute and chronic conditions. Consultations provided by the centers are tracked to analyze trends, practice patterns, and outcomes and to give feedback to clinicians in the field. In addition, the centers also establish clinical management guidelines and policy, create educational materials that summarize critical aspects of care for clinical populations commonly seen at VNSNY, and collaborate on research projects. Another VNSNY system for practice improvement, the Learning Collaborative, is a cross-cutting clinical workgroup that focuses on rapid feedback and movement of principles and practices to care teams across VNSNY programs and teams.

Finally, research capacity (in the form of data archives, staffed positions, and resources for analyzing data beyond the calculation, benchmarking, and trending of P4P indicators) is essential to ensure that quality improvement is driven by a broader perspective on the health care delivery, financing, and policy environment, within the context of an organization's

mission and long-range vision and priorities. Investments in the first three ingredients are important, but there are often important questions about the best approaches to service delivery, including strategies for managing care that target large groups of patients over a horizon longer than that typically tracked by a single provider. Institutional research with these data can provide critical insights to other providers and settings and influence policymakers. Thus, robust research capacity provides an additional return on the investments for data collection and performance management that are essential for P4P.

Remembering Patients and Their Priorities: Challenges and Opportunities for Nursing's Involvement in Health Policy

Nurses have distinct perspectives on the delivery of health care through their close contact with patients experiencing illnesses and life transitions, and their involvement in some of the most personal aspects of direct care delivery. . As a group respected and trusted by the public, nurses have an obligation to consider the impact of P4P on the public today and in the future.

P4P initiatives have not yet become aligned with a broader health care agenda that included patient-centeredness as a key element of system reform (Institute of Medicine, 2001). What is most important to health care consumers? What do they believe they are paying for? In a sound bite, the downstream impacts on health care quality on their survival, and equally, if not more important, their quality of life—their ability to function in daily life and maintain the relationships and activities of most importance. If patients were paying for performance, what would they pay for? They would pay for correct, safe treatments that respected their personal preferences and helped them attain the best functioning in daily life possible (which is, to at least some extent, in the eyes of the beholder). They would be less likely to push for decontextualized measures of adherence to specific practice elements.

P4P has emerged at a time of profound societal changes, including changes in the American experience of aging. Among these are rapid diffusion of technology, democratization of information, and access to services facilitated by the Internet and an expectation that most, if not all, Americans will experience a long and enjoyable old age. Across settings, nurses have provided and continue to provide services that are patient centered, relationship based, and consider broad aspects of patients' experiences in the world, and their social networks. It will be increasingly important to ensure that outcome measures are tracked, reported, and used to drive payment decisions to go beyond measures of patient satisfaction to reflect nurses' contributions to health and adaptation to illness.

Nursing's challenge is to show support for accountability for performance in the health care system while voicing clear opinions and suggestions about the measures and incentive structures used in P4P. The role of nurses in making systems of care “work” for patients is clear—scientific evidence can support investments in nursing services, enhance nursing practice, and reframe discussions to ensure that P4P achieves its intended purposes.

Conclusion

Nurses were among the first stakeholders in American health care to admit that safety and quality in the system were not what they could be. Clinicians in nursing and their leaders embrace clear performance guidelines and accountability for meeting them. Nurses, nurse researchers, and nurse leaders also recognize that limited resources hamper many health care facilities' abilities to meet patient needs and improve quality of care. Informally and unofficially, nurses support the basic ideas behind P4P but are nervous about its implementation. It is interesting that, to date, American nurses have been largely silent regarding P4P. Discussions in the nursing literature and the professional community are just

beginning, probably because P4P initiatives are truly only in their infancy because the impacts of P4P are unknown and many are likely to be indirect. As implementation of P4P broadens, unintended consequences of the initiatives may predominate, or nurses and their leaders may be successful in using the programs and the data that come from them to justify investments in nursing services and solidify the profession's position in the health care system.

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Biographies

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