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RN Compensation Program:

An innovative initiative for direct care nurses to drive outcomes

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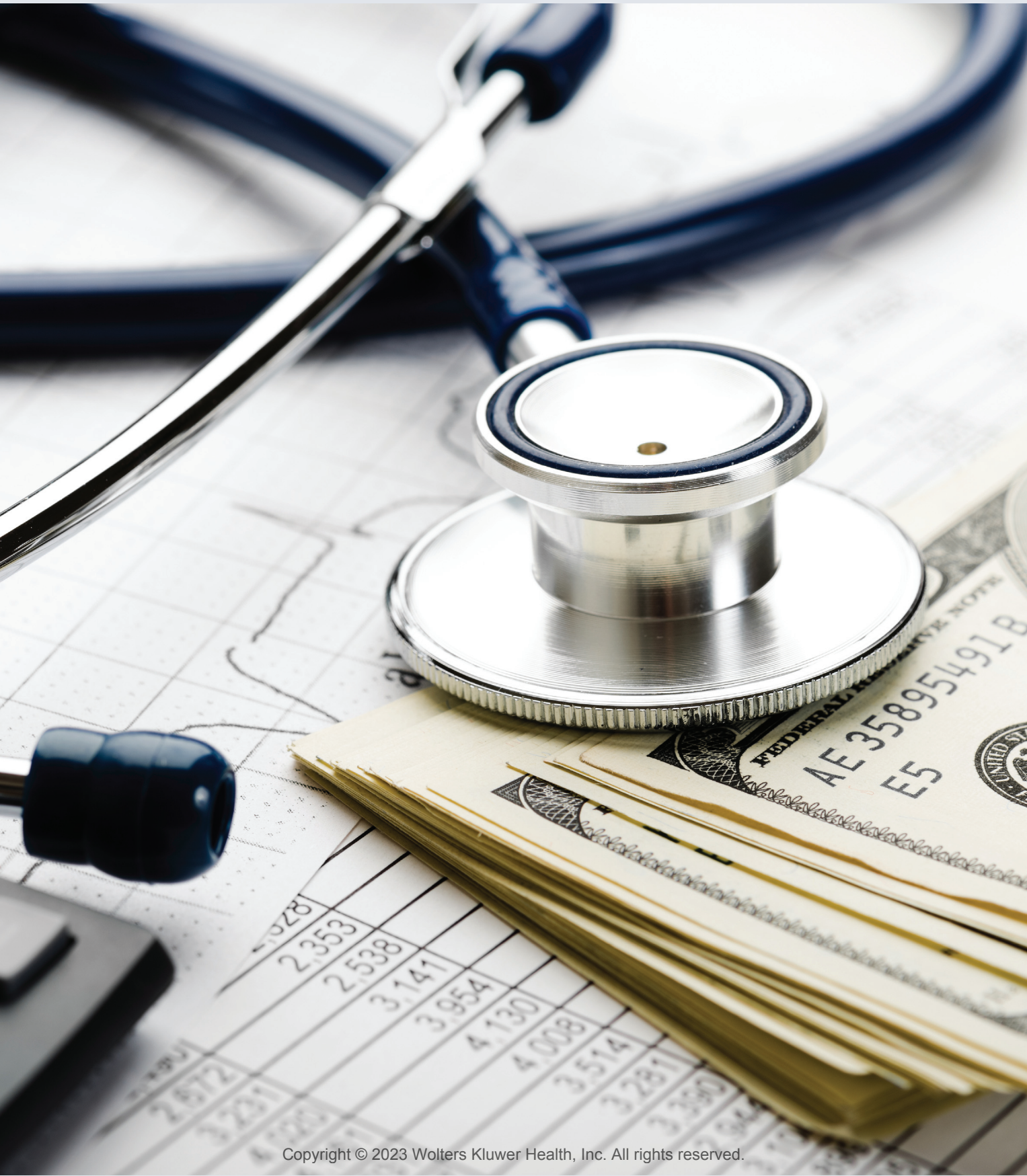
Innovative and meaningful compensation programs to reward direct care RNs for quality outcomes can be used to drive organizational strategic goals. Pay is frequently cited as a dissatisfier among nursing staff. Through the use of innovative compensation programs, nurse leaders can garner the support of nursing staff to drive outcomes while building loyalty, trust, and engagement in their workforce.[1]

The Centers for Medicare and Medicaid Services' (CMS) Pay-for-Performance programs are designed to improve healthcare using financial incentives for quality care and outcomes. The three programs—1) Hospital Readmissions Reduction Program (HRRP), 2) Hospital-Acquired Condition (HAC) Reduction Program, and 3) Hospital Value-Based Purchasing (VBP) Program—all have financial implications for hospitals based on performance on key healthcare quality and patient outcome metrics.[2-4]

The CMS HAC Reduction Program is a value-based purchasing program that bases Medicare payments on healthcare quality for inpatient hospital settings. This program reduces Medicare payments to hospitals that rank in the lowest-performing quartile of all hospitals for HACs. A total HAC score is calculated using six quality measures: 1) Patient Safety and Adverse Events Composite (CMS PSI 90), 2) central line-associated bloodstream infection (CLABSI), 3) catheter-associated urinary tract infection (CAUTI), 4) surgical site infection (SSI) for abdominal hysterectomy and colon procedures, 5) methicillin-resistant *Staphylococcus aureus* (MRSA) bacteremia, and 6) *Clostridium difficile* infection (CDI).[2] Nurses play a key role in the prevention of most of these conditions.



Additionally, research has shown that nursing practice makes a substantial contribution to healthcare quality and patient outcomes. Hospitals with better nurse work environments, better patient-to-nurse ratios, and Magnet® recognition perform better on Pay-for-Performance program quality metrics and have fewer hospital readmissions.[5,6] Hospitals with Magnet recognition must meet or exceed benchmarks for nurse-sensitive indicators such as CLABSI, CAUTI, and hospital-acquired pressure injuries (HAPI) as well as patient satisfaction metrics.[7] This further indicates that nurses make a significant impact on patient outcomes and quality metrics.

In an effort to drive system strategy and compensate nurses for their contributions to patient outcomes and quality metrics, Baylor Scott & White Health set a vision to design an innovative pay program to reward nursing staff. The authors conducted a literature review and found no studies related to paying staff-level structure bonuses for achievement of metrics based on quality and patient outcomes. The executive nursing leadership team designed an innovative bonus program called the Registered Nurse Compensation Program (RNCP), which includes an incentive component to reward nurses twice a year for performance on outcomes. This new program represented a transformational shift in how RNs are rewarded related to their achievements in addition to their annual increase. Market adjustments still occur on a regular cadence to stay in alignment with market competitive salaries. The overarching strategic goal of the program is to incentivize nurses in a meaningful way to strive for high-quality patient-care outcomes while driving zero harm.

Implementation

The RNCP vision began taking shape in 2017 and was implemented in 2018. The chief nurse executive assembled a workgroup consisting of human resources/compensation representatives, CNOs, and analytics representatives to design the program, determine key metrics, set targets, and create the bonus payout structure. The workgroup addressed two key changes related to the current compensation methodology in addition to the RNCP.

The first change involved RNs who had less than 18 months experience. These nurses were in the Step Program, which was designed to incrementally increase a novice nurse's hourly base pay every 6 months for the first 18 months of employment. Under the new RNCP structure, novice nurses would remain in the Step Program for 30 months, during which time they were to receive an hourly base pay increase every 6 months.

The second key change was moving all RNs who were eligible for the RNCP from a merit-based increase to an annual standard increase in base pay. The annual increase is designed to keep base salary aligned with market, and the RNCP bonus is the compensation component that rewards the nurse for achievements in quality and patient outcome metrics. The RNCP bonus can be as high as 7% of base pay per year depending on the experience level of the nurse and performance on the key metrics.

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The workgroup designed the RNCP as an innovative bonus program tied to key metrics that are within the control of nursing practice. They selected the metrics to align with the organization's strategic pillars of service, people, finance, and quality. Initially, metrics were determined for inpatient/hospitals, ambulatory clinics, and hospital RN care managers (see *Tables 1-4*). The workgroup established structures

and processes to ensure that metrics were meaningful and measurable. Parameters for each metric determined where data would be obtained, how data would be calculated, and any other factors to ensure the data were accurate and robust. Examples include:

- ***Service.*** A minimum of 30 surveys will be used to determine metrics for a unit; otherwise, they'll be included within the next-highest level, such as department, facility, or region. The patient satisfaction surveys used by the healthcare system have domains in which similar questions are statistically analyzed (scored) together. The domains used for metrics are determined by the specialty/area of nursing and which domain those nurses can affect most.
- ***People.*** First-year nurse retention at the hospital level (excludes involuntary retention). This metric is about the nurse's control to create a work environment that's team-oriented and promotes reward and recognition. Given a smaller population (a unit, for example), a single voluntary resignation could be devastating to the annual metric. A minimum of 30 employees will be used to determine unit metrics; otherwise, they'll be included within the next-highest level (department, facility, or region). Targets were set in the same way they were for the system service and quality metrics. Each unit or facility/region (if moved up to a higher level) was asked to close 25% of the gap between FY17 baseline performance and the 90th percentile.
- ***Finance.*** Productivity scores will be an accumulation of all

Table 1: Original RNCP inpatient metrics

Pillar	Metric	Weight
Service	Patient satisfaction survey: Nurse communication domain	20%
Quality	CLABSI (10%) Total falls (10%) CAUTI (10%) HAPI (10%)	40%
Finance	Productivity (10%) Length of stay (10%)	20%
People	First-year retention of RNs	20%

Table 2: Original RNCP Central ambulatory clinics' metrics

Pillar	Metric	Weight
Service	Patient experience • Medical practice: Concern of the nurse or assistant for patient problems (10%) and recommend provider office to family and friends (10%) *or* • Urgent care: Nurse concern to keep you informed (20%)	20%
Quality	Population health bundle (20%) Total falls (20%)	40%
Finance	Reduction of 30-day hospital readmission (10%) Productivity (10%)	20%
People	First-year retention of RNs	20%

Table 3: Original RNCP North ambulatory clinics' metrics

Pillar	Metric	Weight
Service	Patient experience • Likelihood of recommending our services to others • Likelihood of recommending our facility to others	30%
Quality	Total falls	10%
Finance	Reduction of 30-day hospital readmission (15%) Productivity (15%)	30%
People	First-year retention of RNs	30%

Table 4: Original RNCP hospital RN care manager metrics

Pillar	Metric	Weight
Service	Patient satisfaction survey: Nurse communication domain	10%
Quality	Readmission reduction (30%) Hospital-level nursing goals (CLABSI, CAUTI, falls, HAPI) (10%)	40%
Finance	Decrease length of stay	40%
People	Voluntary retention of all employees in department	10%

productive hours and target hours as an aggregate over the 6-month measurement period. It will be 100% utilization over the entire measurement period.

• ***Quality.*** Will be based on nurse-sensitive indicators in the National Database of Nursing Quality Indicators® (NDNQI®) benchmarks.

The RNCP design workgroup and executive nursing leadership determined that all direct care nurses and managers would be eligible for the program once employed by the organization for 6 months. P.r.n. RNs have the potential to receive up to 75% of the bonus based on the number of hours they've worked during the previous 6 months on the unit and/or in the hospital. Metrics are measured for a 6-month period to determine the payout amounts, which are paid to the eligible RNs twice a year.

Each RN has an individual dashboard that's updated monthly. The compensation statement provided at the end of each measurement period outlines their performance against the metrics and the bonus earned. The first payout under the RNCP was paid in the Spring of 2018 for the measurement period of July through December 2017.

Evolution of the RNCP

The workgroup and CNOs from the facilities throughout the system met at least monthly during the initial implementation period to share feedback on the design and process of the RNCP. It quickly became apparent that there was a need to have specific metrics defined for specialty areas such as the neonatal intensive care unit (NICU), the OR, and obstetrics (OB). The North and Central ambulatory care clinics' metric scorecards were combined into one system standard ambulatory care metric scorecard. Direct care nurses working in the respective specialty areas in those clinics expressed that they were finding it difficult to connect the metrics to their area and their individual contribution.

Additionally, the direct care nurses provided feedback for improving the metrics, including eliminating the productivity and voluntary retention metrics because the individual nurse didn't perceive that they had control over these metrics. The workgroup developed the new scorecards to align with the new strategies within the healthcare system (health, experience, and affordability), which had replaced the previous pillars (service, quality, finance, and people). The methodology for measuring the metrics was updated to align with how the system measured performance in these areas, and complexity was reduced wherever possible (see *Tables 5-9*).

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Patient-facing nurses such as disease-specific program coordinators and managers gave feedback indicating that they'd also like to participate in the RNCP. The workgroup reviewed the list of eligible job codes and added other patient-facing job codes, which were aligned with the most appropriate type of metric scorecard based on the overall responsibilities of the job code and where those nurses had the most impact on patient care.

Table 5: Current RNCP NICU metrics

Strategy	Metric	Weight
Health	HAPI (16.66%) CLABSI (16.67%) Expressed breast milk at discharge (16.67%)	50%
Experience	How well did nurses help you understand your baby's treatment and daily progress?	30%
Affordability	Readmission reduction (10%) Length of stay (10%)	20%

Table 6: Current RNCP ambulatory care areas metrics

Strategy	Metric	Weight
Health	Falls with injury	40%
Experience	Patient experience: likelihood of recommending our services to others Patient experience: likelihood of recommending our facility to others	40%
Affordability	Readmission reduction	20%

Table 7: Current RNCP OR metrics

Strategy	Metric	Weight
Health	HAPI (10%) Wrong surgery, wrong site, wrong patient (10%) Surgical burn to drape/patient (10%) Unidentified retained foreign object (10%) ERAS (Enhanced recovery after surgery): colorectal only (10%)	50%
Experience	Patient satisfaction survey data	30%
Affordability	First case on-time starts (percentage of first OR cases that started on time)	20%

Table 8: Current RNCP OB metrics

Strategy	Metric	Weight
Health	Falls with injury (16.66%) Unidentified retained foreign object (16.67%) Exclusive breast milk feeding (16.67%)	50%
Experience	HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) nursing domain	30%
Affordability	Readmission reduction (10%) Length of stay (10%)	20%

Table 9: RNCP revised inpatient metrics

Strategy	Metric	Weight
Health	HAPI (6.25%) Falls with injury (6.25%) Hospital-acquired infections SIR (standardized infection ratio) numerator composites (CAUTI, CLABSI, MRSA, CDI, SSI-colon, SSI-hysterectomy) (37.5%)	50%
Experience	Patient satisfaction survey data	30%
Affordability	Readmission reduction (10%) Length of stay (10%)	20%

In the Step Program, novice nurses receive a progressive base rate increase every 6 months, but nurses who weren't in the Step Program requested a return of the performance-based increase. Based on this feedback and to provide further financial recognition to top contributors, the healthcare system reintroduced performance-based annual merit increases.

Empowering nurses and improving care

Since the inception of the RNCP, the system has experienced improvements in all metrics with many of the facilities, units, and departments outperforming national benchmarks a majority of the time. For example, the vacancy rate prior to the COVID-19 pandemic was at 5% (with zero use of agency nurses) and is currently (March 2023) at 5.8%, down from a high of 20.9%. Falls with injury are down from 2.15 to 1.64 per 1,000 patient days. CAUTI rates are down from 1.22 to 0.51 per 1,000 patient days.

Facility and department metrics are reviewed annually to determine if the metric goal will remain the same or be adjusted to drive further improvement. Regular communication with key stakeholders in the form of monthly performance updates, huddle board updates, and a leadership tool kit are used to keep everyone informed about progress toward goals.

This unique and transformational program was continued throughout the COVID-19 pandemic with strong results. It has not only driven improved

patient outcomes in the healthcare system, but it has strengthened what's offered to the nursing workforce. Incentivizing direct care RNs in a meaningful way further empowers nurses in the ownership of the care they're providing thus driving outcomes. By understanding their role in strategic initiatives, direct care nurses within the system have been instrumental in assessing, planning, designing, and implementing nurse-led patient care and evidence-based practice initiatives to improve the quality and perception of care delivered. NM

REFERENCES

1. Bradley C. Utilizing compensation strategy to build a loyal and engaged workforce. *Nurse Lead.* 2021;19(6):565-570.
2. CMS.gov/Centers for Medicare & Medicaid Services. Hospital readmissions reduction program (HRRP). 2023. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program. Accessed August 15, 2022.
3. CMS.gov/Centers for Medicare & Medicaid Services. Hospital-acquired Condition Reduction Program. 2022. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program. Accessed August 15, 2022.
4. CMS.gov/Centers for Medicare & Medicaid Services. CMS' value-based programs. 2021. www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HVBP/Hospital-Value-Based-Purchasing. Accessed August 15, 2022.
5. Dierkes AM, Riman K, Daus M, Germack HD, Lasater KB. The association of hospital Magnet® status and Pay-for-Performance penalties. *Policy Polit Nurs Pract.* 2021;22(4):250-257.
6. Lasater KB, Germack HD, Small DS, McHugh MD. Hospitals known for nursing excellence perform better on value based purchasing measures. *Policy Polit Nurs Pract.* 2016;17(4):177-186.
7. American Nurses Credentialing Center. *2019 Magnet Application Manual.* Silver Spring, MD: American Nurses Credentialing Center; 2017.

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