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Nursing is Revenue, Not Expense

Overview

Historically, nursing has been an expense line in health care systems' budgets (Nandaprakash, 2023). Nursing is the largest workforce and the largest operational cost in health care (Garcia, et al., 2024). Nursing care accounted for more than 50% of operational costs in U.S. hospitals in 2022 (American Hospital Association, 2022). Based on nurses' valuable contributions to positive patient outcomes and the impact of nursing interventions, nursing should be considered as a revenue line because the reason that in-patient hospital admissions exist is for the provision of nursing care (Ogundeji, 2020). Quality nursing care decreases length of stay, minimizes nosocomial infections, prevents readmission, reduces falls, and improves quality indicators (Hatfield, 2024; Nickitas & Nanof, 2023; Wan & Tang, 2022).

Issue

In the 1920's nurses were private contractors who billed patients directly for the nursing services provided. As in-patient hospitals transformed as the centralized location for the delivery of advanced medical and surgical care, nursing services were needed around the clock. Patients then received bills for hospital services and supplies, physician care, and private duty nursing care. In the 1930's, these private duty nurses were identified as competition by the hospitals, so they began to employ their own nursing staff billed as room and board charges to control the money paid for nursing services. Reimbursement models were developed with no inclusion of nursing services (Love, 2022). The definition and attempt to capture the value of nursing services has continued to be discussed and conceptualized ever since (Schwartz and Swanson, 2024).

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Current Environment

Nursing services are included in room and board charges on a patient's in-patient bill, making the profession invisible to both payors and patients (Hoddinott, 2024; Love, 2022; Nickitas & Nanof, 2023). Following the recent pandemic, the role of nursing has become more visible to the public; however, many still do not understand nursing's full scope of practice, the roles nurses perform, and the ethical standards under which they practice (Chabal & Hibbert, 2023; Gelinas, 2023; Nickitas, 2024; Pandemic…, 2020). Not all patients require the same amount of nursing care, just as not all patients require the same amount of medical decision-making, procedures, diagnostic studies, etc. (Ogundeji, 2020). Respiratory therapy, phlebotomy, occupational therapy, and other members of the health care team charge by procedures, treatments, and time involved. Some hospitals charge patients more based on the unit where they are admitted; however, the nursing care required is not specifically costed out, so these additional charges are just financial estimates (allnurses, 2003).

Because nursing services cannot be billed separately in the current reimbursement structure, health systems, needing to maintain a viable bottom line, cut nursing positions increasing nurse patient ratios. Although this investment in nursing has long-term implications for improving patient, community, and world health outcomes, the staff cuts provide short term improve the hospital financial reports for the short term (Hatfield, 2024; Love, 2022; Yakusheva, et al., 2022).

Arguments in Favor

Hospital financial decisions are based on cost data and reimbursements based on outcomes. Daily nursing billing provides the cost data, helps quantify the value of nursing

services, improves the patient outcomes, and decreases the risk of patient deaths (Defining…, 2024; Firth, 2024; Hewner, et al., 2018; Lucatorto, et al., 2016). This is tangible revenue that can also be used to monitor and assess implemented care efficiencies (Malley, et al., 2024; Rutherford, 2012). For example, studies conducted at the University of Pennsylvania have shown that, "for each additional patient the average nurse takes care of, the odds of in-hospital mortality, longer lengths of stay, and 30-day readmissions increase significantly. In New York, the researchers estimated that if hospitals maintained safe nurse staffing levels, 4,370 more patients would live, and $720 million would be saved through shorter length of stay and avoided readmissions" (Love, 2022).

Recommendations

Delineating charges

Nursing services can be separated from room and board charges. Identification of the actual nursing services provided can then be costed out and submitted for reimbursement. These reimbursements would be direct revenue generation, savings in patient positive patient outcomes, decreased length of stay, and decreased readmission rates would be indirect revenue streams (Yakusheva, et al., 2024).

Track nursing services within the current documentation system

Another recommendation is for individual nurses to apply for and use unique nurse identifiers. Most advanced practice nurses (in New York these would be Clinical Nurse Specialists, Certified Nurse Midwifes, and Nurse Practitioners, sadly, New York does not currently recognize Certified Registered Nurse Anesthetists) are registered in the Centers for Medicare and Medicaid Services (CMS) Unique Provider Identifier (NPI) Registry to be able to

bill and be reimbursed for Medicare and Medicaid services. There is no charge to register, and registration is available to any licensed nurse (ANA, 2022; CMS, 2022; Nickitas & Nanof, 2023).

Another unique nurse identifier is one that every Registered Nurse and Licensed Practical Nurse already has but may not be unaware of. It is the identifier assigned by the National Council of States Boards of Nursing (NCSBN) for the Nursys ® database. This identifier is assigned at the time of initial licensure and is used to aggregate nursing data for research.

Many of the electronic health care record systems (EHRs) can support the use of unique nurse identifiers. Use of unique identifiers would allow researchers, patients, payors, and health care systems the ability to identify, measure, and track the time, value, and impact of nursing care (Alliance, n.d., Chan, et al., 2023; Ogundeji, 2020; Sensmeier, et al, 2019).

Change reimbursement model

Nationally, the American Nurses Association is working to encourage the Center for Medicare and Medicaid Innovation to explore different reimbursement models for nursing following the model for most other healthcare practitioners. Although CMS is only one payor, CMS policy drives other third-party reimbursement providers (Hatfield, 2024; Olenick, 2022).

Bill directly for services

Nurses could work as independent contractors like most anesthesiologists. Instead of being hospital employees, they can contract and bill for the services provided as had been done in the 1920's. Nurses and nursing care generate volumes of data and yet there remain gaps in the ability to capture and analyze this data. Impediments to operationalize nursing value and demonstrate its return on investment include various care models, customized documentation

systems, complex acuity calculators, underuse of standardized nursing terminologies, and variety of settings and contexts in which nursing care is provided (Garcia, et al., 2024; Hatfield, 2024; Love, 2022; Ogundeji, 2020).

Conclusion

"When healthcare systems can stop treating nurses as costs, and rather as a reimbursable service, the inherent misalignment in healthcare over nurse staffing levels can be resolved, and with it, the nursing shortage. Some may argue that we cannot afford to do this, but the reality is, if we want there to be a sustainable future for the nursing profession, improved patients' outcomes and viable healthcare systems, we can't afford not to" (Love, 2022).

Resources

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