External Recognition in QI

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Recognition

Recognition acknowledges achievement of goals, successful outcomes, and quality of care for healthcare organizations. Recognition is awarded at many levels: to the organization, a department, or individuals. External recognition of care and services serves as a public evaluation compared to other similar organizations, which organizations use for self-promotion and marketing. An organization that undergoes a thorough external assessment of structures, processes, and outcomes, through evaluation of best practice implementation, available resources, and results, projects a commitment to quality and improvement. Leaders learn where their organization stands in comparison with others, positive or negative. External survey sponsors recognize excellent performance expressed as rankings or ratings based on these comparative data and information. National surveys repre-

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sent a broad spectrum of healthcare organizations. Survey response data serve as a benchmarking tool suitable to foster quality improvement efforts.

Several organizations publish information about healthcare organizations: for-profit companies who use rankings or ratings, such as "honor roll," "best of," or "top" lists, to sell products, publications, and magazines, and some organizations publish data to inform healthcare decision-making. Two organizations that publish rankings and ratings for hospitals are the US News & World Report, a for-profit, and the Leapfrog Group, a nonprofit. These organizations' websites identify their annual rankings/ratings as comprehensive drivers of improvement in safety and quality. According to The Leapfrog Group, their top hospital awards and ratings recognize hospitals with lower error and infection rates and higher quality in measured care areas [1]. The US News & World Report suggests that ranking hospitals and publishing results assist patients in locating the best available care for their condition [2]. Patients and families, applicants for positions, and potential donors consider ratings to determine if the healthcare organization is the right place to receive care, to work, and to provide funding. But hospitals and specialists also use the published information to compare their skills and outcomes with others named in the rankings. Rankings are typically based on quantitative data, such as metrics and outcomes, and on qualitative information, often open-ended questions. These externally reported comparisons drive competition whether intended or not and, like an organizational report card, incentivize improvement and frankly drive improvement and prioritization of resources to improve care delivery.

Federal and state agencies and selected collaboratives publicly report healthcare data that compare generally accepted best practices, processes, and outcomes across hospitals or among clinician groups [3]. These data are generally collected from repositories, such as Medicare. Peer-reviewed articles on the use of survey information and publicly reported data for hospital quality improvement initiatives are available for review. However, the reader cannot conclude that improvement necessarily occurred.

Quality of care initiatives were more likely to show improvement, but it is difficult to determine if improvement in patient safety or patient experience occurred [4].

Surveys

Surveys, in general, are used to collect information and feedback to increase knowledge. Survey design drives the quality of the information received and includes many formats, such as open-ended questions, multiple-choice, multipoint scales or ratings, or ranked preferences. Companies use surveys to learn about consumer preferences, customer satisfaction, or understand employee engagement. Surveys designed to elicit concrete information on the quality or availability of services provided offer a transparent comparison for consumers [5].

External healthcare surveys use a similar approach: collect information on specific aspects of care from organizations or data repositories and report publicly to guide consumer decision-making. Healthcare organizations use survey data to frame and drive improvement initiatives. Survey results provide benchmarking tools for comparing processes and outcomes against those who attain "best of" or "top-ranked" status. Participation in the survey process provides the hospital a self-assessment of internal processes and outcomes and comparison to expected results.

Participation in external surveys varies. The Leapfrog Group Hospital Survey is voluntary, requiring organizations to weigh the benefit and use of information learned from the survey process and results. The US News & World Report "Best Hospitals" adult specialty ranking, published since 1990, includes the American Hospital Association (AHA) member hospitals that fit the survey eligibility requirements. Specialty ranking relies on data available from government and association resources, such as the Centers for Medicare and Medicaid Services patient experience survey (HCAHPS), AHA survey, and specialty group resources. They track patient mortality, volume, staffing ratios, and/or expert

physicians' opinions [2]. Their Pediatric Hospital Survey is voluntary, and hospitals must provide a comprehensive survey with general information and extensive data on applicable pediatric specialties to be considered for inclusion.

The US News & World Report Pediatric Hospital Survey and The Leapfrog Hospital Survey rely primarily on self-reported data from submitting organizations. According to the US News & World Reports' online methodology for Best Children's Hospitals, they published the first pediatric rankings based on data in 2007. Since 2008, results have included data on specialty care, with more comprehensive survey data collected annually. Survey questions encompass clinical structures, processes, and outcomes. Data reflect clinical best practices in use, staffing resources, volumes of patients and procedures, and specific clinical outcomes [6]. The Leapfrog Group's website notes that the survey began in 2001 and expanded measures over time [7]. Both survey sponsors retrieve data from external sources when available, such as the Centers for Disease Control External Healthcare Safety Network (NHSN) database and other external data sources with hospitals self-reporting the remainder of information requested. The surveys report that responses are scrutinized using robust processes to ensure valid and reliable data, comparing expected to observed responses and margins for acceptable answers. Survey sponsors request clarification from submitters on any data that are deemed to be out of the expected range for confirmation of responses prior to accepting their survey for publication.

Decisions to participate in voluntary surveys reside at the leadership level as an organizational commitment. Survey completion requires input from numerous content experts in coordination with staff who collects, analyzes, and inputs information into the survey platforms and leaders who validate and verify content prior to submission. To facilitate data collection, robust electronic medical records and information technology platforms are preferred versus manually capturing information from records. Leaders should evaluate the cost of data collection and verification and committed staff time for survey completion in considering participation, determining the return on investment for their organization internally. After survey submission and receipt of published results,

leaders determine the best utilization of published results, with information suitable to drive quality improvement initiatives.

Survey Results: Driving Improvement

Once survey results are publicly reported in various formats, organizations have a foundation to improve care using the improvement (QI) process. There are numerous methods to employ in improving quality, such as the Model for Improvement, Lean/Six Sigma, cause analysis, and process mapping. Survey results, as reported, offer basic information and data for organizational response and improvement. The survey sponsors referenced above offer additional opportunities to purchase comparative information: The Leapfrog Group Competitive Benchmarking Reports [8] and US News Hospital Data Insights database [9].

Once the results are available, the QI process begins: review results, compare with benchmarks and your organization's previous results when available, identify improvement opportunities, and prioritize based on importance to patients and the organization. Prioritization should consider the teams who will be charged to make improvements. Microsystems, teams of healthcare members who care for a particular patient population, are an appropriate group to engage in improvement. The US News & World Report Pediatric Hospital Survey results encompass ten specialty groups, and adult hospital surveys rank 16 specialty areas, each inclusive of microsystems. In addition, selected indicators cross specialty groups and encourage the engagement of other professionals in a multidisciplinary improvement approach. Hospital-acquired infections, hand hygiene, and medication processes cross disciplines and microsystems.

Organization support staff, such as patient safety, performance improvement, and patient experience specialists, might round out improvement teams. The organization's expertise to guide and support QI correlates to the capacity and capability to make improvement. Capacity denotes the organization's commitment to educate staff in improvement science to equip them with knowledge and skills to engage in improvement initiatives. Capability

refers to building a comprehensive support framework for staff, such as QI and safety department consultants, time to participate in improvement activities, and reinforcement to undertake QI initiatives to improve patient care, safety, or experience.

Well-defined survey data focus the improvement effort, guiding the development of an aim statement that outlines the desired outcome, specific population, and timeline for accomplishment. Microsystem teams identify improvement strategies or key drivers to accomplish the aim: develop processes to improve patient care delivery procedures and outcomes, remove impediments to care access, increase volume, and implement best practices for safe effective care. Measurement is essential to gauge progress with the aim, using benchmarks as comparators.

Achieving improvement within microsystems and across the organization is gratifying for staff, leaders, and the patients who benefit from excellent care, something they expect. Using QI processes as described allows multiple teams to engage in improving care specific to their areas or that will affect care across the continuum. A good starting place is identifying the "low-hanging fruit" or those improvements that are easy to undertake. Hand hygiene is addressed on surveys, with questions about specific compliance measured and processes and practices in place. Once identified as a concern, QI methods might include reviewing and updating policies, evaluating reasons for noncompliance, setting expectations, observing staff compliance, and offering just-in-time education for noncompliance. The outcome is easily measured and compared organization wide. Questions regarding available FTEs may present low-lying solutions if hiring additional resources will improve care and financial resources are available. Reviewing scores for expected numbers of nurses, social workers, or specialty patient/parent educators may justify adding staff. Reviewing current structure and processes may lead to additional specialists, new technologies, or patient support services. Reorganizing structure to allow additional provision of services may be appropriate and improve processes and outcomes. The ability to offer influenza immunizations to specialty clinic patients may be a goal. The structure in place to obtain and store the vaccine needs to be considered with the process of administer-

ing the vaccine. Is a licensed staff member available to complete the process? Successful implementation of this QI effort could improve structure, processes, and patient outcomes. Focusing on the process of barcode medication administration scanning compliance engages multidisciplinary teams and potentially reduces medication errors to improve outcomes. The team sets an aim to increase compliance, determines barriers to scanning, develops key drivers to address the barriers, tests potential changes, and measures scanning compliance and medication administration errors to determine outcomes.

Survey questions drive higher-level QI when considering reductions in hospital-acquired conditions, prolonged length of stay, readmissions, or deaths. The QI process and methods remain the same: using data to identify areas for improvement, setting a goal, and implementing the correct actions. The microsystem team likely needs assistance from QI professionals and data analysts. The positive aspect of this type of improvement is that best practices for infection reduction are available for consideration, and small tests of change are easily conducted. Collect and analyze outcome and process data to measure improvement. The QI initiative should be spread and sustained, with the potential to be recognized externally as data are shared.

Other areas for consideration that vary in ease of implementation are specialty accreditation and designation as a Magnet® hospital. Leaders drive decisions to pursue this level of achievement. Rigorous standards must be met, leading to fertile ground for process and outcome QI. Magnet Recognition Program® designation and national organization accreditation favorably impact survey results and are excellent examples of external recognition.

Magnet® Designation

Achieving recognition as a Magnet® designated organization is the highest honor an organized nursing service can achieve. In 1983, the American Academy of Nursing Taskforce on Nursing Practice in Hospitals published their sentinel study, *Magnet Hospitals: Attraction and Retention of Professional Nurses*,

which created the evidence base for today's American Nurses Credentialing Center's (ANCC) Magnet Recognition Program [10]. Over the 25-year history of the program, the Commission on Magnet Recognition (COM), the governing body of the Magnet program, has increasingly raised the bar for the performance of Magnet-designated organizations. Initially focused on the 14 forces of magnetism, factors found to influence recruitment and retention, the Magnet standards have evolved an outcomes-based model that are essential to a culture of excellence and innovation in nursing practice [10]. The Magnet standards are rooted in a strong, independent scientific base that spans 20 years of research and development.

The Magnet model consists of five components: structural empowerment; exemplary professional practice; new knowledge, innovation, and improvements; and transformational leadership all of which underpin the final component, empirical outcomes. The model acknowledges that global issues in nursing and healthcare impact the five Magnet domains (Fig. 18.1). Each of the five

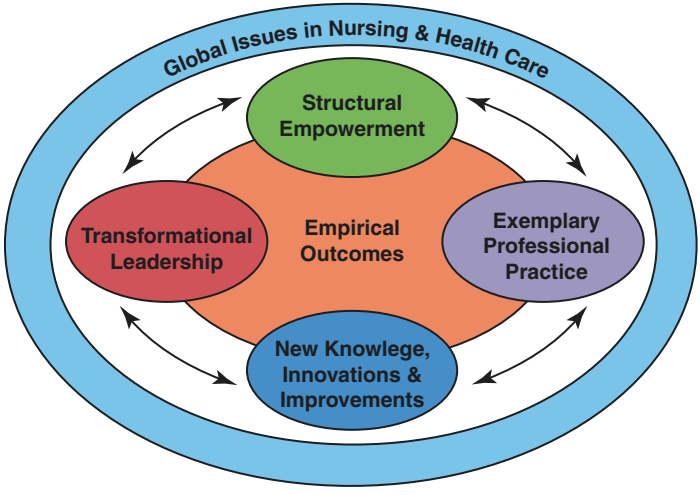

Fig. 18.1 ANCC Magnet® model. The Magnet model consists of five components: structural empowerment; exemplary professional practice; new knowledge, innovation, and improvements; and transformational leadership all of which underpin the final component, empirical outcomes

components has a series of sources of evidence (SOE) that must be met by the applicant organization to achieve Magnet designation. Once achieved, the designation period is 4 years, during which time designated organizations will participate in an interim monitoring report and begin the redesignation process.

Before applying for Magnet designation, organizations should complete a gap analysis based on the current Magnet application manual standards. Tools and resources for organizations considering Magnet designation are available from the ANCC Magnet Recognition Program website. It is imperative that organizations understand the eligibility requirements, the Magnet model, and the required sources of evidence before beginning the application process.

The process to achieve Magnet designation consists of four major elements: application, submission of documents, a site visit, and Commission on Magnet decision. The application is the first step and declares the organization's intent to submit written documents. During this phase, organizations will submit documentation regarding the organizational structure, qualifications of the chief nursing officer (CNO), and other nurse leaders, as well as other documents establishing the eligibility of the organization. Following the application, organizations will prepare and submit documents, the second phase of the designation process. This stage of the process can take from several months up to a year or more depending on the readiness of the organization at the time of application. The documents contain examples of how the organization meets the SOE under each of the components of the Magnet model and tells the story of the contributions of nurses to the empirical outcomes achieved by the applicant. The requirements for the documents are very specific and must be followed clearly and precisely to be appropriately evaluated and scored by the appraisal team. Once the documents are submitted, they are reviewed and scored by an independent appraisal team. The results of the document submission phase could be one of the three following scenarios: the document does not meet the standards, and the application process ends; the document meets the minimum thresholds, but additional documentation is required; or the document meets the standards, and the organization advances to the

next phase of the appraisal process, the site visit. Organizations that required additional documentation are given a one-time opportunity to provide additional examples and data in order to move to the site visit phase. The site visit is the highlight of the journey for many organizations on the Magnet journey. The visit is conducted by the same team of appraisers who reviews and scores the document. The purpose of the site visit is to clarify, amplify, and verify the contents of the written document. Once the site visit concludes, the appraiser team submits a written report to the COM, who makes the final determination of designation status.

Since the inception of the Magnet program, numerous studies have examined the impact of implementing the various elements of the Magnet model on the organization. Work culture, retention, nurse-sensitive outcomes, and patient satisfaction are a few of the areas which have been widely examined in the literature. The strong scientific basis of the Magnet Recognition Program continues to evolve as the program itself continues to grow. Once a modest program centered on hospitals in the United States, the Magnet Recognition Program has grown to over 500 designated hospitals worldwide.

Recognition, such as a Magnet Recognition Program®-designated organization, Leapfrog Top Hospital, or US News Best Hospital, represents a beginning, not an end, to improving quality. As you dive into survey data to determine what and how to improve, many opportunities may emerge. Over time, QI efforts mature and result in overall performance improvement, followed by recognition at many levels: internal and external. But also consider that other organizations are attempting to improve quality with the same consequences of better outcomes and improved ratings and rankings, pushing the bar for the quality of care and external recognition higher. The cycle continues. Quality improvement in clinical outcomes, processes, and structures readies the organization for the next survey submission. Quality improvement involves everyone working together to attain excellent results and positive outcomes. A top survey ranking or rating externally recognizes that an organization values and provides the best quality patient care. In the end, the winners are the patients receiving top-notch care and the staff choosing to work in externally recognized healthcare organizations.

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