The Development of an Accreditation Toolkit: A Quality Improvement Initiative

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**Abstract**

**Problem Statement**: Urgent care centers (UCCs) are not required to be certified or accredited in any state, however, accreditation is an essential measure of healthcare quality and shows outside endorsement of meeting set quality and safety standards. Through accreditation, UCCs gain a market and financial advantage in showing a commitment to quality and safety in meeting set standards established by an accrediting body. Currently, few UCCs in Michigan are accredited, creating great variations in the quality and safety of care from one center to another. Emcura Immediate Care (Emcura) is one such UCC in Michigan that is currently not accredited but seeks accreditation to show this commitment to their patients and to stand out from other UCCs in the area as maintaining this higher standard.

**Purpose**: Emcura located in Bloomfield Hills and Novi, Michigan, sought to become an accredited UCC through the Urgent Care Association (UCA) and required leadership in this endeavor. The advance practice registered nurse (APRN) and Doctor of Nursing Practice (DNP) candidate acted as project facilitator to perform a quality improvement project at Emcura. The project intent was to lead a multidisciplinary team through the beginning phases of the accreditation process through the UCA and create an accreditation toolkit to guide Emcura in the accreditation process when prepared.

**Methods**: The Institute for Healthcare Improvement (IHI) Model for Improvement (MFI) and Lewin’s Change Theory (LCT) were used to lead a multidisciplinary team at Emcura through the self-assessment and gap analysis phase of accreditation. The self-assessment and gap analysis were guided by the accreditation standards of the UCA. Emcura was then asked to decide whether to pursue accreditation immediately or to wait for application. An accreditation toolkit was created by the project facilitator to act as a guide for Emcura when ready to apply for accreditation.

**Analysis**: Plan-Do-Study-Act (PDSA) cycles, consistent with IHI MFI were used during the self-assessment and gap analysis to ensure the project stayed organized and that all components of the UCA accreditation standards were evaluated against current clinical practices, policies, procedures, and environment. The accreditation toolkit was then be created and evaluated by the DNP committee and Emcura for usefulness to the organization as a guide for future accreditation.

**Significance**: Through accreditation, standards for quality and safety must be met and contribute to increased quality of care for patients of UCCs like Emcura. However, accreditation takes time, commitment, and leadership expertise that UCCs may lack. The DNP prepared APRN possess the leadership skills needed to help guide UCCs through the accreditation process and is skilled at identifying gaps and seeking solutions to fill them. Leading Emcura through the early stages of the accreditation process of organizational self-assessment and gap analysis, with creation of an accreditation toolkit, provides the perfect symbiotic format for Emcura and the project facilitator of this DNP project. Emcura learned more about their organization and the accreditation process and was left with a toolkit as a guide for future accreditation. The project facilitator was able to utilize DNP prepared APRN experiential skills to lead Emcura in this endeavor and in creation of the accreditation toolkit. This project provided the project facilitator with an opportunity to function in a consultant role and opens the door for further advancement on policy in the regulation of UCCs to influence changes in current practice.

**Introduction**

Urgent care centers (UCCs) exist to fill a gap for patients between primary care and emergency department (ED) care in providing quick, convenient, and affordable care when their primary care provider (PCP) is unavailable, or when a presenting condition does not require expensive emergency care (“What is urgent care”, 2018). The American Academy of Urgent Care Medicine (AAUCM) defines urgent care as the delivery of prompt medical care, in an outpatient setting, for acute and chronic illness and injuries (“What is Urgent Care”, 2018). In recent years, there has been a proliferation of UCCs to meet this need (Yee, Lechner, & Boukus, 2013). As of June 2017, there are more than 7,639 UCCs in the United States (U.S.) (Japsen, 2018). Growth in the urgent care industry was 11% from 2016 to 2017 and is expected to continue growing (Japsen, 2018). Michigan currently has 611 UCCs at the time of this writing (“Michigan 611 Urgent”, n.d.).

Though hospitals and other large healthcare organizations are often accredited by an accrediting organization, surprisingly, no regulations exist that require an UCC to be accredited or certified in any state (“Industry FAQs”, 2018). Without consistent regulations and standards in place governing UCCs, the quality of care can vary from one center to another. It is difficult to regulate UCCs because there is a wide variety in practice models. UCCs can range from small privately-owned offices to large hospital or multispecialty based practices, or to private equity-backed chains. As UCCs have traditionally been regulated as physician practices, the focus has been on physician conduct and licensure overseen by state medical boards (Ayers, 2015). This model of regulation, however, does not cover the operational complexity of growing organizations that do not fit the usual physician’s office model (Ayers, 2015). Therefore, states have been focusing regulation on defining urgent care as attempts at regulation are difficult until a clear definition of urgent care as a separate entity is obtained (Ayers, 2015).

Accreditation is known to be an essential measure of health care quality and assures patients and payers that an organization, or facility, has outside endorsement of meeting set quality and safety standards (Nouwens, van Lieshout, Bouma, Wensing, 2014; Urman & Philip, 2014; Winchester & Hendel, 2017). To ensure that UCCs are meeting quality and safety standards, and to offer UCCs a competitive edge in the market, in 2014 the Urgent Care Association (UCA) began the first accreditation and certification program for UCCs (“20 Things”, 2015). Few UCCs currently have this accreditation. Only 985 UCCs nationwide and two centers in Michigan, out of more than 7,000 UCCs nationwide, have this designation (“Find an Urgent Care”, n.d.).

Being accredited also gives facilities a market edge over their competitors. Consumer behaviors are changing, and customers are now seeking out cost effective and high-quality care they can trust (Lang, 2017). Accreditation gives organizations a seal of approval that indicates to consumers that a set standard of care quality is being met (Lang, 2017). Patients have clear expectations through meeting consistent standards and can choose to only go to accredited centers (Valori et al., 2013). This market edge and the potential financial gain associated with having a larger patient population than other UCCs creates motivation for sustainability for UCCs that are accredited.

**Problem Statement**

Since implementation of the Patient Protection and Affordable Care Act’s (ACA) health insurance marketplace in 2013, an increasing number of patients are turning to UCC’s and ED’s for quick, convenient care of both episodic and chronic conditions because of primary care provider (pcp) shortages, affordability, operation outside of usual business hours, and ease of access without an appointment (“20 Things”, 2015; Block, 2014). In recent years, there has been a rapid rise in the number of UCCs in the country to meet the rising demand for this care. UCCs are popular with patients for providing affordable and convenient care (“20 Things”, 2015). Currently, however, it is not required that UCCs be certified or accredited in any state (“Industry FAQs, 2018). This lack of standardization means that quality can vary widely among UCCs. However, UCC leaders may lack the time, commitment, or expertise to obtain accreditation.

There are few accredited UCCs in Michigan as accreditation is not required. Emcura, like most of these UCCs in Michigan, is not currently accredited. The organization seeks accreditation through the UCA to show a commitment to safe and quality care to their patients and for potential market and financial benefits available through accreditation. Also, like most UCCs, they will benefit from the leadership and guidance in this endeavor. The project facilitator can fill this gap for Emcura in offering leadership and assistance in the accreditation process and in providing them the tools they need to navigate the accreditation process when ready to apply.

**Purpose**

This DNP project assisted Emcura, a privately-owned UCC, in suburban Detroit, Michigan, through the early stages of the accreditation process. Using the Institute for Healthcare Improvement’s Model for Improvement [IHI MFI] (“Science of Improvement”, 2019), the project facilitator, led this quality improvement project at Emcura through the self-assessment and gap analysis phase of accreditation and then created an accreditation toolkit for Emcura to use as a guide for future accreditation. The future goal of Emcura is to become one of the few UCCs in Michigan to obtain accreditation through the UCA and show their commitment to quality and safety in providing care. They will do this when ready using the accreditation toolkit created in this project. The purpose of this DNP project is to help prepare Emcura for accreditation through self-assessment and gap analysis of the current practice environment and creation of an accreditation toolkit to guide them through the accreditation process when they are prepared.

**Clinical Questions**

How can the project facilitator assist Emcura in performing an organizational self-assessment and gap analysis using LCT and the IHI MFI?

Can the information learned in the self-assessment and gap analysis be used to create an accreditation toolkit to guide Emcura through the accreditation process when they are ready?

**Literature Review**

**Search Strategy**

For the purposes of this DNP project, inclusion criteria were any type of study, or scholarly article, that discussed healthcare accreditation and quality improvement. CINAHL and PubMed were utilized using the following search terms: healthcare, accreditation, quality, improvement, safety, urgent care, and ambulatory care. Studies published between 2013 and 2018, written in English were included. As no articles or studies specific to urgent care accreditation could be found, other settings were considered. Any articles containing information focused primarily on accreditation outside of healthcare, such as in education, or that only focused on quality improvement and not specifically on the effects of accreditation on quality improvement were excluded. A total of 28 articles were retrieved. Each article was reviewed by the project facilitator to ensure relevance of topic and whether it met inclusion criteria. Any articles with exclusion criteria were withdrawn. The remaining nine articles were evaluated for study design, level of evidence, study quality, risk of bias, and relevance. The results of the studies were then synthesized from the nine articles that were relevant and met inclusion criteria. Of the nine articles reviewed, four were quantitative design (stepped-wedge study, qualitative grounded theory study, empirical interrupted time series analysis, and randomized controlled trial), four were qualitative (literature review, scholarly review articles). One article was relevant evidence from experts and not a true research study, but also included due to their pertinence to the topic.

**Benefits**

According to the literature, accreditation is generally considered an acceptable method to measure and improve the quality and safety of healthcare organizations (Desveaux, Mitchell, Shaw, & Ivers, 2017; Nouwens, et al., 2014; Winchester, 2017). However, while accreditation does provide an objective measure of quality and safety performance, research on the overall effect of the accreditation process on quality improvement is sparse (Devkaran & O’Farrell, 2015; Ng et al., 2013; Winchester, 2017). Also, previous research focused on the effects of accreditation on healthcare quality have yielded inconsistent results (Devkaran & O’Farrell, 2015). Several studies were reviewed to determine how accreditation affects quality of care, for this literature review, and these showed inconsistent results (See Appendix A).

Bogh et al., (2017) performed a multi-level longitudinal, stepped-wedge study of process performance measures to assess the effect of a mandatory accreditation program in all Danish public hospitals. Data from 624, 518 processes of care was obtained on outcomes such as stroke, heart failure, ulcers, diabetes, breast cancer, and lung cancer from national clinical quality registries. The researchers evaluated weekly trends in hospital care over a period of 269 weeks; before, during, and after accreditation. The results showed improvement in quality of care during the study period.

Nouwens, et al., (2014) performed a block design, two-arm cluster randomized controlled trial (RCT) of primary care practices, with a focus on cardiovascular risk management (CVRM), to evaluate the effectiveness of improvement designs in practice accreditation. The intervention group of primary care practices (n=22) were told to concentrate improvement strategies on CVRM during the intervention. The control group of primary care practices (n=23) could focus on any domain except CVRM and diabetes mellitus (DM). Systolic blood pressure <140mmHg, LDL cholesterol <2.5mmoll, and prescription of antiplatelet drugs were the predetermined primary outcome measures. Secondary outcome measures included the physician’s perceived goal attainment and 17 indicators of CVRM. The results showed there was no effect on the primary outcome measures. In six of the 17 indicators, secondary outcomes did improve; exercise control, diet control, smoking status, recording of alcohol intake, waist circumference measurement, and fasting glucose. Therefore, the practice accreditation program led to some improvements on CVRM, but not on the primary outcome measures.

A qualitative grounded theory study on how accreditation may influence quality was performed by Desveaux, et al., (2017). This study took place in Ontario, Canada and included publicly funded health services accredited by Accreditation Canada. The researchers studied a sample of 115 healthcare organizations that had voluntarily participated in Accreditation Canada’s ‘Qmentum’ program between January 2014 – June 2016. The sample was further divided to identify a portion of 22 organizations for a variety of sampling characteristics, such as organizational size and geography. A semi-structured interview of individuals that had participated in coordination of the accreditation process or were involved in supporting quality was done. It was found that the accreditation is considered a quality assurance process if it aligns with organizational priorities. Three mechanisms influence how accreditation influences quality: coherence, organizational buy-in, and collective quality improvement action. Further, the experience of the accreditation process by an organization is influenced by internal and external factors, as well as individual characteristics (Desveaux et al., 2017).

Devkaran & O’Farrell (2015) performed an empirical interrupted time series analysis to assess the influence of accreditation on quality measures. The study took place in Abu Dhabi, United Arab Emirates in a 150-bed multispecialty hospital over a 48-month period. Twenty-seven quality measures were compared over monthly intervals, in 2009, 1-year pre-accreditation, and in 2010, 2011, and 2012, 3 years post-accreditation. Data was extracted from 12,000 random patient records from a population of 50,000 records during the entire study period from January 2009 to December 2012. The results showed significant improvement in 74% of the measures during pre-accreditation. However, there was a significant negative effect in 48% of the measures during the post-accreditation period. After the survey, accreditation had significant negative change (26%) compared to a positive change (7%). Overall, accreditation had no significant impact on 11 of the total 27 measures. A lasting benefit of accreditation was noted with preserved performance of approximately 90% in 2012 from the baseline in 2009. The researchers concluded that despite a temporary decline in performance directly following the accreditation survey, the improvements made due to accreditation were sustained during the three-year accreditation cycle.

The above studies of the effects of accreditation on quality improvement show that overall quality is improved through accreditation. However, according to Devkaran & O’Farrell (2015), the process of accreditation is focused on process improvements and not on clinical outcomes. Devkaran & O’Farrell (2015), also expressed concern that accreditation is meant by organizations to create a confidence in payers, patients, and the public in the quality of care they provide, but that there is no real assurance that the care delivered by accredited organizations ensures quality. Of the literature reviewed, Devkaran & O’Farrell (2015) were the only authors to voice this concern.

The research of Bogh et al., (2017) supports that hospital accreditation does lead to patient care improvements and Nouwens et al., (2014) concluded that some clinical outcome improvements were made through accreditation, though not on the primary outcome measures, as previously mentioned. Further, Winchester & Hendel (2017), state that accreditation promotes the adoption of standards and provides for an independent review process that confirm the quality of healthcare services. Accreditation is also reported to emphasize continuous quality improvement and a commitment to quality of the organizations that undergo the accreditation process (Urman & Philip, 2014; Winchester & Hendel, 2017).

Another advantage of accreditation is that it benefits patients, health professionals, hospitals, and professional organizations (Valori, Rogers, Johnston, & Ingham, 2013). The benefit to patients is in the assurance accreditation provides that an organization meets defined standards of care. For health professionals, accreditation provides motivation to provide the highest level of care and recognizes their successes. Accreditation provides a voice and influence for professional organizations in advocating for evidence-based standards of care and assures they are meeting acceptable standards (Valori, Rogers, Johnston, & Ingham, 2013).

Ng et al., (2013) support that accreditation has additional benefits to organizations, such as improved staff communication and engagement, team building, positive cultural changes, and heightened staff awareness of continuous quality improvement. This is supported by Winchester & Hendel, (2017) that accreditation can be an encouraging factor in creating a culture of quality. Benchmarking against other accredited facilities is another added benefit of accreditation according to Urman and Philip (2014).

Other benefits of accreditation are the financial and market advantages to organizations that achieve it (“Urgent Care Center”, 2018). Increasingly, payers are requiring organizations to be accredited to remain in-network and before contracting. Further, a risk management credit of 2.5% to 15% on their premium is offered by medical malpractice insurance carriers (“Urgent Care Center”, 2018). Accreditation also creates a sense of consumer confidence and provides a marketing and referral advantage to accredited UCCs (“Urgent Care Center”, 2018; Valori, Rogers, Johnston, & Ingham, 2013). The combination of cost savings through decreases in medical malpractice rates and potentially increased patient base due to increased consumer confidence and referrals provide a substantial financial benefit to accredited UCCs.

**Challenges**

While accreditation offers many benefits, it also presents some challenges. Valori et al., (2013) state that accreditation can be a burden on organizations’ undertaking it. The process of accreditation requires great effort and time in achieving standards, collecting and reviewing evidence, acting on evidence, and presenting evidence. Strong collaboration must take place to maximize the potential of accreditation and minimize the risk that it will become too taxing.

Desveaux et al., (2017) acknowledge that accreditation is an accepted process in which to assess performance of an organization and implement quality improvement initiatives, but successful implementation of new processes during accreditation involves constant work and is influenced by internal and external factors as well as individual characteristics of those involved in the process. The authors stress flexibility in both application and response of changes during the accreditation process. For quality improvement to occur and be sustained, coherence and buy in of participants is necessary for success.

Ng et al., (2013) support the idea that accreditation can be challenging and discuss several factors that affect implementation. Funding can become an issue for organizations to achieve accreditation. Staff communication and engagement can play a role, either positively or negatively, in the accreditation process. The accreditation process also increases the workload on staff (Ng et al., 2013).

**Summary**

Though the relevant literature found and reviewed regarding the effects of accreditation on quality of care specifically in healthcare was sparse, what is available largely supports accreditation as a measure of quality and safety, and financial and market advantages are gained through accreditation. Through the standardization of processes that meet acceptable, evidence-based standards set forth by the UCA, accredited UCCs show a commitment to continuous quality improvement that sets them apart from nonaccredited UCCs.

**Conceptual Framework**

The Institute for Healthcare Improvement (IHI) Model for Improvement (MFI) was used by the project facilitator as a framework to guide improvement during the pre-accreditation process (Appendix B). The IHI MFI is a tool used to accelerate improvement and is a useful instrument for many quality improvement projects. The model consists of two parts: three fundamental questions and Plan-Do-Study-Act (PDSA) cycles. The three questions are: 1.) How will we know a change is an improvement? 2.) What are we trying to accomplish? and 3.) What change can we make that will result in improvement? The questions can be applied in any order (“Science of Improvement”, 2018).

The IHI MFI recommends following seven steps for process improvement. First, a team should be formed. Ideally, the team should include the right people interested in enacting change and making quality improvements. The right team is critical to the success of a quality improvement project. Next, the team should set aims for the project. The aims should be measurable, time specific, and include defined patient populations and other systems involved. Once the aims have been set, the team must establish measures to ascertain if a change has taken place. Changes are then selected from ideas from team members or outside sources. PDSA cycles are then used to test real work setting changes. Each PDSA cycle includes planning it, doing it, studying the results, and acting on what is learned. Changes should first be tested on a small scale. What is learned from these small-scale changes is then refined through several PDSA cycles, each one larger than the other, until implementing the change on a broader scale. Lastly, once a change has been implemented successfully, it can be spread to an entire population, unit, or organization (“How to Improve”, 2018).

**Theoretical Framework**

The theoretical framework to guide this project was Lewin’s Change Theory (LCT). LCT is a three-stage model for change developed by Kurt Lewin, who was known as the father of psychology. The three stages of his theory are: 1.) unfreezing, 2.) change, and 3.) refreezing and the theory further consists of three main concepts: driving forces, restraining forces, and equilibrium. Driving forces promote and advance toward change. In the setting of this project, driving forces will include the project facilitator, as leader of the project, and the team developed and involved in application of the project. Restraining forces work against and hinder progress toward change. An anticipated potential restraining force in this project was possible staff resistance to change. Equilibrium is when no change occurs and there is a balance between driving and restraining forces. At the beginning of the project, equilibrium for Emcura was the current state of the organization. Once change is made, the goal would be to reach a new state of equilibrium after adoption of the standards set in place for accreditation. For the model to work, former learning must be rejected and replaced (“Change Theory”, 2011).

In the first stage of the model, unfreezing, old patterns and habits must be unlearned. This stage is often focused on dealing with restraining forces in the form of resistance to change. Other factors can play a role as well, such as time constraints. The resistance can be from individuals or a group. Unfreezing can be managed in three ways. The first is to increase driving forces to push away from the present circumstances and toward change. The second is to decrease the restraining forces keeping change from happening. The third is to do both; increase driving forces and decrease restraining forces (“Change Theory”, 2011). In applying this stage to the accreditation project, efforts were focused on attempting to decrease resistance to the inevitable changes that will happen during the process. Education was provided to the team regarding accreditation, to include what it means for the urgent care, why it is being sought, how the process will be completed, who is responsible for making specific changes, and what changes need to be made individually and collectively for a successful survey. A communication plan and timeline were established.

During the change stage, changes are made to thoughts, feelings, behaviors, or all three. The change should be made to a new pattern that is more valuable than the previous one. Once change has occurred, refreezing happens. This is a stage where new habits are accepted over old ones as the new operating procedure (“Change Theory”, 2011). The accreditation standards were reviewed with the team involved in the self-assessment and gap analysis. The changes necessary to meet the UCA accreditation standards were discussed so that all involved in the process knew what to anticipate as a new normal. The value of the changes and in accepting a new normal were stressed to help move people through the unfreezing stage and into the change stage. As no changes would be made in this project, education regarding the changes needed to meet the UCA accreditation standards was given.

It is important during refreezing to monitor for, and quickly correct, a return to prior patterns and habits. Once Emcura decides to make changes and apply for accreditation, it will be key to monitor new habits closely in the beginning to ensure that staff does not return to old habits (“Change Theory”, 2011). The project facilitator will educate the physician owner and manager to anticipate this stage, plan for it, and refer to the accreditation toolkit created when needed to keep themselves on track with the accreditation process. When they decide to follow through with accreditation, the new normal will eventually become routine and only yearly staff competencies and education of new staff will be needed on the new standards consistent with maintaining accreditation. Encouragement was provided by the project facilitator to the physician owner and manager to expect and plan for this.

**Methodology**

**Setting**

This quality improvement project was carried out at Emcura Immediate Care, Bloomfield Hills, Michigan. The six exam room facility averages approximately 60 patients daily and sees patients of all ages. The hours of operation are from nine o’clock a.m. to nine o’clock p.m. Monday through Thursday and nine o’clock a.m. to six o’clock p.m. on Friday, Saturday, and Sunday. Staff involved directly with patients include a registration clerk, two medical assistants, and two providers; either two physicians or one physician and one nurse practitioner (NP) or physician assistant (PA). The clinic offers comprehensive urgent care services to include x-ray, point of care labs, lab draws on site, minor office procedures, medication administration including intravenous fluids, and immobilization devices. Emcura also has an on-site apothecary for supplements, which is unique to UCCs in the area. Supplies for musculoskeletal care, such as splinting, crutches, and orthotics are provided. Electrocardiograms (ECGs), spirometry, and respiratory care is also available within the clinic. The on-site lab meets the Clinical Laboratory Improvement Amendments (CLIA) standard for laboratory quality and safety.

**Participants**

The first step in the IHI MFI, before implementing the two core parts, is to form the team (“How to improve”, 2018). The team involved initially in the project included the project facilitator, the physician owner, key stakeholders, Emcura’s DNP nurse practitioner (NP) and committee chair, the office manager, and two staff members; a medical assistant (MA) and registration clerk. The committee chairperson is a DNP with a strong background in emergency and urgent care medicine and quality improvement. Together, the entire team had the expertise for this quality improvement project to be successful.

**Ethical Considerations**

As a quality improvement project involving an organization, this project did not involve human subject research and no ethical conflicts or issues are identified. As informed consent, a letter was obtained from the physician owner allowing the project to be done at Emcura (Appendix D). Participation by the stakeholders at Emcura was purely voluntary. No financial or other incentives were provided, and no coercion of any type was made. There was no anticipated harm to any individual person or the organization as a result of participation in this project. Confidentiality was strictly maintained and no information regarding the organization, or any person within the organization, was divulged other than for purposes of disseminating and presenting the details of the project. Only relevant components related to this project were shared. The University of Detroit Mercy’s (UDM) IRB determined that no human subjects were involved in this study and it was quality improvement and not subject to continuation review (Appendix C).

**Procedure**

The project consisted of four distinct phases consistent with the PDSA cycles of the IHI MFI; self-assessment (plan), gap analysis (do), evaluation of readiness for application for accreditation (study), and development of an accreditation toolkit (act) [Appendix D]. The project facilitator led the team in self-assessment of the current practices, policies, procedures, and clinical environment against the accreditation standards of the UCA. Once self-assessment was completed, a gap analysis was performed by the project facilitator, physician owner, and office manager to determine the current state of operations compared to the standards of the UCA. The gap analysis was used to evaluate readiness for application for accreditation. The project facilitator created an accreditation toolkit for Emcura to use as a guide when ready to actively seek accreditation and finish the process.

The project began with the first step of the IHI MFI with formation of the team. The team then began to create a plan, set aims, plan future meetings, and develop a timeline. The aims were set by answering the three questions of the IHI MFI; 1. How will we know a change is an improvement?, 2. What are we trying to accomplish?, and 3. What change can we make that will result in improvement. All staff members were initially invited to join the project by the physician owner. The final project team consisted of staff members actively interested in involvement in the project, with representatives from different roles in the organization.

Once the team was formed, the team began the IHI MFI planning stage of the PDSA cycle by asking and answering the three questions of the model and setting aims. First, the team addressed the IHI MFI question; what we are trying to accomplish? Ultimately, we were trying to accomplish meeting the accreditation standards of the UCA to obtain accreditation. Our first aim was to develop a plan for how to perform a self-assessment within two weeks. The next question of the IHI MFI addressed was, what change can we make that will result in an improvement? Eventually, Emcura would want to make any policy, procedure, and environmental changes needed to be compliant with the UCA accreditation standards. But, for purposes of this project, our second aim was performing a thorough self-assessment of the current policies, procedures, and clinical environment and subsequent gap analysis toward making changes that would result in improvement and move towards accreditation within two months. Lastly, we examined how we would know a change is an improvement. Our final aim was to use the UCA accreditation standards and preparation manual to measure and compare current practice to the standards to see what changes will result in an improvement and for the project facilitator to create an accreditation toolkit after the gap analysis from this comparison within one month of the gap analysis.

The UCA accreditation standards and preparation manual was already available and issued to the clinic through inquiry of the physician owner to the UCA. The manual acted as a guide for the project for the self-assessment and gap analysis. The current state of operations was evaluated in each category of the manual against the standards of the UCA. The manual contains a checklist of UCA standards in seven categories. Each of the categories contains a set of standards that must be met within that area for accreditation to be obtained.

LCT as the theoretical framework for the project, was incorporated from the beginning. The first stage of the theory, unfreezing, started with the physician owner, key stakeholders, and office manager from the beginning of the project as both are in the stage of equilibrium with the current state of the processes and procedures at the clinic. They needed a driving force to help guide them to new ways of thinking and away from their current state of equilibrium. As they are leaders in the clinic, the rest of the staff will look to them as an example, so it was important for them to unfreeze from old behaviors and feelings. The driving force at the start of the project was the project facilitator. During the planning phase, it was expected the physician owner and office manager would begin to look forward to change and become the driving force with the project facilitator for the rest of the project, but initially the project facilitator was the driving force for them as the project facilitator does not work for Emcura and does not have any pre-existing feelings or behaviors to change. The project facilitator acted as a consultant and was a recommending body and not a decision maker. The intent was for the entire to team to later act as the project’s driving force to promote and advance change within the entire organization to meet the standards of UCA accreditation.

In the planning phase, a self-assessment of the clinic was planned to take place, using the UCA standards as a guide and measure of current practices and processes. The project facilitator and office manager worked collaboratively to lead the organizational self-assessment and results were reported back to the physician owner and the rest of the team. This continued the first phase of the project and aligned with the end of the plan portion of the PDSA cycle. Organizational self-assessment was important in determining what processes were already in place consistent with the standards of the UCA, so that efforts would only be focused on changing and implementing what was lacking. Using the accreditation standards and preparation manual issued by the UCA, each category was reviewed by the project facilitator and office manager to assess if the standard was currently in place at Emcura. Sections of the self-assessment checklist were assigned to other team members as appropriate. The UCA standards were compared against the current policies and procedures in place. It was anticipated that this phase would take about two months to accomplish.

In the next phase of the PDSA cycle, the ‘do’ phase, a gap analysis was done. A comprehensive list was created of what processes, policies, procedures, and environmental changes needed to be put in place and implemented according to the information gathered from the self-assessment and gap analysis. Over the course of several scheduled meetings, arranged during the planning phase, between the physician owner, project facilitator, and office manager gaps were identified from the organizational self-assessment. This phase addressed the IHI MFI question three; what change we can make that will result in improvement. The change stage of LCT started to take place during this phase. The members of the team began learning new ways of thinking, processes, and behaviors that needed to change within the organization in order to achieve accreditation. The gap analysis was anticipated to take about one month to complete.

The third phase began the ‘study’ phase of the PDSA cycle. The second question of the IHI MFI, how will we know that a change is an improvement, was the focus of this phase. The physician owner and office manager then needed to evaluate readiness for application for accreditation and decide whether to actively pursue accreditation at this time or wait until they are best prepared. In order to be fully prepared for accreditation, they will need to be able to make all the necessary changes to the policies, procedures, and environment identified in the gap analysis. They would also need to create and perform staff training once the changes are made on the new policies and procedures. Ensuring they have the necessary fees for accreditation would be important as well. All of this must be considered when assessing readiness for application for accreditation. This phase involved LCT’s stage of change. This was the phase in which individuals were ‘unfrozen’ and expected to move toward change. This is a challenging stage of LCT as change becomes real and participants struggle with the new reality. It was anticipated that this phase will be take about two weeks.

The final step of the project was the ‘act’ phase of the PDSA cycle when the project facilitator developed the accreditation toolkit. The toolkit was developed as a guide in the process of UCA accreditation for Emcura to use should they decide to wait for a later time in which to apply, or to complete the process of accreditation in this phase of the project. This phase was anticipated to take about one month to conclude.

The final stage of LCT of refreezing did not take place during this project as this stage can only be done after changes to policies, procedures, environment, and practices at Emcura have been made in accordance with the accreditation standards. This stage would begin with educational sessions on the new policies and procedures during this final step should Emcura apply for accreditation. In LCT, this would be the stage in which new processes are accepted, then reinforced and maintained as the status quo. As application for accreditation did not occur, there were no new processes to accept, reinforce, or maintain currently. Refreezing would be anticipated later, outside of this project, once the changes for accreditation are complete and put into place. Completion of the entire project occurred when the goal of development of an accreditation toolkit was accomplished. The total project was expected be finalized within five months.

**Analysis**

As a quality improvement project to develop an accreditation toolkit as a guide for Emcura to use when ready to apply for accreditation, success of the project was evaluated by successful completion of the three anticipated phases of the project; self-assessment, gap analysis, and creation of the accreditation toolkit. Through participation in this project, Emcura learned about themselves as an organization and of how to make quality and safety improvements, based on the UCA accreditation standards, to improve clinical practices. The ultimate success of this project was in creating the accreditation toolkit to help guide Emcura in the accreditation process and in guiding the organization in performing a self-assessment and gap analysis of the current state of practices against the UCA accreditation standards manual.

**Strengths**

The project began as planned initially and the PDSA cycles of IHI MFI and LCT provided good structure to the project. The IHI MFI and LCT were helpful frameworks in completion of this quality improvement project. The IHI MFI helped form the structure of the project, particularly in setting aims and planning. The PDSA cycles of the IHI MFI kept the project on track despite the challenges faced. During challenging times, refocusing on the phases of the PDSA cycles helped bring the project back on track. LCT was also an accurate and helpful framework for the project. Unfreezing was evident in the beginning phases of the project as the team members of Emcura participated in the self-assessment and gap analysis and began to realize the changes that would need to take place within the organization in order to obtain accreditation through the UCA. Consistent with LCT, as unfreezing began and when faced with the reality of change and number of changes that would need to take place, the team developed hesitancies regarding moving forward toward accreditation. Refreezing did not take place in this project, as the changes were not yet made toward accreditation, but this stage would occur once the organization makes the changes identified in the gap analysis and moves toward application for accreditation.

In the beginning of the project, a team was formed that consisted of key stakeholders and represented a variety of roles within the organization; the project facilitator, DNP committee chairperson and provider in the clinic, physician owner, office manager, MA, and registration clerk. A timeline and plan were created for the self-assessment and gap analysis. Aims were set and aligned with the three questions of the IHI MFI. The process of unfreezing, according to LCT, began as the team members involved in the project began to evaluate through self-assessment the changes that would need to occur in order to obtain accreditation through the UCA.

After the self-assessment was completed, using the UCA accreditation standards manual as a guide, a gap analysis was performed. The gap analysis was completed by the project facilitator and office manager and the findings were regularly communicated to the physician owner by the office manager. The organization ultimately decided to apply for accreditation later to give them the opportunity to work on the needed accreditation infrastructure utilizing the accreditation toolkit developed as a guide. An accreditation toolkit was successfully created by the project facilitator for the organization to use as a guide when prepared to seek accreditation through the UCA based on what was learned in the project.

**Limitations**

The largest challenge noted in this project, was in keeping the team to the originally established timeline and plan. Several factors may have played a role in making this a challenge. First, the project facilitator was the only person that did not work within the organization. This created a learning curve for the project facilitator as the leader of the project. Not only did the project facilitator take on a key role in the entire project, but the project facilitator had to learn what the current practices, policies, procedures, and environment was in order to help the organization in performing the self-assessment. Extra time should have been allotted for this in performance of the self-assessment.

Also, the self-assessment was originally planned to be divided amongst the team members, however, the clinic is very busy and high volume. Staff found participation in the project difficult in addition to their priority of providing patient care. Therefore, the self-assessment took much longer than originally planned as the project facilitator and office manager were involved in the majority of completing it. Once the self-assessment was completed by the project facilitator and office manager, a gap analysis was completed by them through a series of telephone meetings. Scheduling these meetings could at times be problematic as well due to outside obligations and schedules of both. At times there were large gaps of time that elapsed between these meetings.

Following the gap analysis, there were some hesitancies noted in the organization’s motivation to continue the accreditation process due to the large amount of work needed to overcome meet all the UCA standards. Consistent with LCT, during the unfreezing and moving into change stage was when the team seemed to be unsure about further progression toward accreditation at this time due to the uncertainty of change and the amount of changes that would need to take place. It was at this time that the organization decided to not follow through with accreditation now. Focus was then placed solely on completion of the accreditation toolkit.

**Discussion**

Important lessons were learned for all involved in this quality improvement project. First, the stakeholders of Emcura learned a great deal about the organization and of the accreditation process. This knowledge will help them improve in quality and safety for their patients whether they decide to seek UCA accreditation. Second, staff involvement and stakeholder buy-in is crucial to a successful quality improvement project and to any organization during the accreditation process. Staff involvement has many benefits. Staff engagement decreases the workload greatly and increases the chances for success as staff are ultimately who will be implementing and following the standards set in place. Staff involvement turned out to be a shortcoming of this project. The project facilitator failed to keep all staff involved in the project. In the future, a secondary plan to engage staff throughout the quality improvement process should be created and followed. In hindsight, more regular staff meetings should have taken place in this process also.

Lastly, flexibility is the most important lesson learned on this journey. The flexibility employed by everyone in this process lead to increased insight for the leadership of Emcura on their organization. For the project facilitator, it was learned that leadership must be flexible and adaptable. Overall, this project provided an opportunity for learning and growth for all involved and though Emcura decided to not seek accreditation through the UCA at this time, the accreditation toolkit successfully created will help guide them through the process when they are prepared to do so.

**Significance and Implications**

As mentioned previously, obtainment of accreditation takes time, commitment, and leadership expertise that UCCs may lack. The focus of the DNP prepared APRN is to provide leadership, through application of the DNP Essentials and learned skillset, in improving healthcare outcomes through identification of gaps and implementing evidence-based solutions to fill them (Sherrod & Goda, 2016). As the accreditation process stresses the adoption of standards based on current evidence informed practice, and DNP prepared APRN possesses the skillset to provide leadership to organizations, such as Emcura in seeking accreditation. Leading Emcura in the early phases of the self-assessment stage of the accreditation process, performing a gap analysis, and subsequent development of an accreditation toolkit, will help Emcura’s leadership and staff better understand the accreditation process and provides an ideal format for the project facilitator to provide the guidance and leadership Emcura needs in the accreditation process by utilizing the unique skillset of the DNP prepared APRN.

The DNP prepared APRN possesses the skills to be key in influencing changes in practice and policy. In acting in a consulting role in this project, the DNP prepared APRN project facilitator learned a great deal about the importance of inter-professionalism and teamwork to bring to similar projects. Opportunities for change in policy regarding the need for regulation of UCCs was recognized as a future area for the DNP prepared APRN to influence change as gaps exist in UCC regulation. This DNP project was disseminated through presentation to key stakeholders, project team members, and other invited guests, such as university faculty, friends, co-workers, and family.

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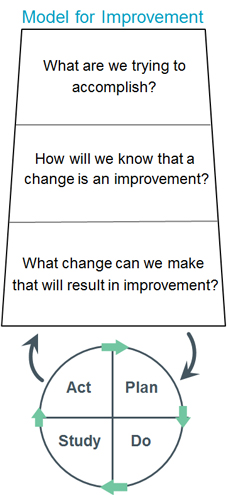
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**Appendix A – Literature Table**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Citation/Year | Literature Type/Design | Sample/Population | Intervention | Instruments | Results/Outcomes |
| Bogh et al., 2017 | Multi-level longitudinal, stepped-wedge study | Data from 624, 518 processes of care was obtained on stroke, heart failure, ulcers, diabetes, breast cancer, and lung cancer from national clinical quality registries | None | None | The results showed improvement in quality of care during the study period. |
| Desveaux, Mitchell, Shaw, and Ivers, 2017 | Qualitative grounded theory study | 115 publicly funded organizations that voluntarily pursued accreditation between January 2014 – June 2016 through Accreditation Canada’s ‘Qmentum’ program. Subset further to 22 eligible organizations. Final interview of 24 participants directly involved in quality improvement | None | Data analysis of semi-structured interviews. Inductive approach using three stages of open, axial, and selective coding with constant comparative technique. | Individual characteristics and contextual factors influence organizational experience of accreditation.  Coherence, organizational buy-in, and quality improvement action are mechanisms which influence the accreditation experience of an organization |
| Devkaran & O’Farrell, 2015 | Empirical interrupted time series analysis | Twenty-seven quality measures were compared over monthly intervals, in 2009, 1-year pre-accreditation, and in 2010, 2011, and 2012, 3 years post-accreditation. Data was extracted from 12,000 random patient records from a population of 50,000 records during the entire study period from January 2009 to December 2012 | None | None | Despite a temporary decline in performance directly following the accreditation survey, the improvements made due to accreditation were sustained during the three-year accreditation cycle. |
| Ng et al., 2013 | Literature Review | Two electronic databases, Medline (OvidSP) and PubMed, were systematically searched. “Public hospital”, “hospital accreditation”, and “quality improvement” were used as the search terms. A total of 348 citations were identified and 26 articles were included in the review. | None | None | Through connecting the findings to the operational issues of accreditation, this review observed the implications for successful implementation and how accreditation may direct quality improvement. These findings have implications for various stakeholders (government, the public, patients and health care providers) on accreditation. |
| Nouwens, et al., 2014 | Two-arm cluster randomized controlled trial with a block design | Primary care practices in the Netherlands that applied to start the practice accreditation program.  Primary care practices allocated to the intervention group (n = 22) and a control group (n = 23) | Intervention group were instructed to focus improvement plans during the intervention period on CVRM.  The control group could focus on any domain except on CVRM and diabetes mellitus.  Primary outcomes were systolic blood pressure <140 mmHg, LDL cholesterol <2.5 mmol/l and prescription of antiplatelet drugs. Secondary outcomes were 17 indicators of CVRM and physician's perceived goal attainment for the chosen improvement project | Descriptive data were analyzed using the SPSS 16.0 software package | None of the primary outcomes showed significant improvements.  Six of the 17 secondary outcomes showed significant improvements. No significant improvement was seen in the other 11 secondary outcomes. |
| Sherrod, B. & Goda, T., 2016 | Peer reviewed scholarly review article | None | None | None | DNP programs provide education and training, through learning of the DNP essentials, in executive leadership that can affect change within healthcare organizations and systems, or within state and/or national policy development. DNP prepared leaders possess key traits to create change in complex healthcare environments. |
| Urman, R., & Philip, B.,2014 | Perspective scholarly review article | None | None | None | Discussion of benefits of accreditation, including external validation of safe practices, benchmarking or performance, and demonstration of commitment to quality improvement and safety |
| Valori, R., Rogers, C., Johnston, D., & Ingham, J., 2013 | Perspective scholarly review | None | None | None | Article discusses issues of a standardized accreditation across services for medical, psychiatric, and surgical centers and services in England and proposes ways to move forward in this endeavor. The authors state accreditation has an important role in a quality focused National Health Service (NHS). |
| Winchester & Hendel, 2017 | Perspective scholarly review | None | None | None | Discusses accreditation in cardiology imaging, both the benefits and challenges. Overall, asserts that accreditation creates a culture of quality and acts as an extension of the Institute of Medicine’s (IOM) quality framework. |

**Appendix** B **– IHI MFI Visual**



Appendix C – IRB Approval

rb@cayuse.com

Thu 8/20/2020 1:28 PM

Aug 20, 2020 1:27 PM EDT   
  
Rebecca Brink   
McAuley Nursing   
  
Re: Initial - IRB-C-#20-21-11 Quality Improvement in Urgent Care Through Accreditation: The Development of an Accreditation Toolkit   
  
Dear Rebecca Brink:   
  
University of Detroit Mercy Institutional Review Board has rendered the decision below for Quality Improvement in Urgent Care Through Accreditation: The Development of an Accreditation Toolkit.   
  
Decision: No Human Subjects Research   
  
Findings: This study is not subject to continuation review.   
  
Research Notes:   
  
Sincerely,   
University of Detroit Mercy Institutional Review Board   
  
Michelle Wheater, Ph.D., IRB Chair   
Assistant Dean for Academic Administration, Research, and Scholarly Achievement   
School of Dentistry, Room 465   
2700 Martin Luther King Jr. Blvd, Detroit, MI 48208   
office: (313) 494-6656 fax (313) 494-6643   
email: [wheatemi@udmercy.edu](mailto:wheatemi@udmercy.edu)

**Appendix D – Project Phases and Anticipated Timeline**

Appendix E – Permission Letter to Complete Project at Emcura

