Minnesota Department of Health

Magnet Hospitals: A Positive Approach to Minnesota's Nursing Shortage

December 2001

Office of Rural Health & Primary Care
121 East 7th Place/Suite 460
St. Paul, MN 55101
1-800-366-5425
www.health.state.mn.us

Report to the Minnesota Legislature

Magnet Hospitals: A Positive Approach to Minnesota's Nursing Shortage

---

December 2001

For more information, contact:
Office of Rural Health & Primary Care
Minnesota Department of Health
121 East 7th Place, Suite 460
St. Paul, MN 55101
Phone: (800) 366-5424
Fax: (651) 297-5808
TDD: (800) 627-3529

As requested by Minnesota Statute 3.197: This report cost approximately $2900 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or cassette tape.

Printed on recycled paper.

Table of Contents

Tables

Executive Summary

An aging Registered Nurse (RN) workforce combined with stagnant graduation trends, strong employment growth, increased staff turnover and heightened employer demand have contributed to the creation of an acute shortage of RNs in Minnesota. Given the novelty and complexity of the problem, addressing the state's current and future need for RNs will require a number of innovative solutions. *Magnet Hospitals: A Positive Approach to Minnesota's Nursing Shortage* examines the Magnet Nursing Services Recognition Program, a national hospital accreditation program which recognizes health care organizations that provide high quality nursing care and support professional nursing practice, as one innovative approach for addressing Minnesota's nursing workforce dilemma.

The 2001 Minnesota Legislature directed the Minnesota Department of Health to examine the Magnet Nursing Services Recognition Program and develop recommendations for incentives that may be implemented to increase the number of magnet hospitals in Minnesota. In October 2001, the Minnesota Department of Health convened a panel of nursing workforce experts and health care providers in order to identify magnet hospital incentives. Based on information collected from the expert panel and secondary information collected on the Magnet Nursing Services Recognition Program, The Minnesota Department of Health has developed the following four recommendations:

- **Recommendation 1:** The Minnesota Department of Health recommends that the Minnesota Hospital and Healthcare Partnership, the Minnesota Nurses Association and other interested professional organizations, in consultation with the Minnesota Department of Health, immediately plan and undertake an effort to publicize and promote the magnet hospitals program within the state. This could include publishing informational materials and newsletter articles, making magnet hospitals information available at conventions, conferences, and other professional gatherings, and other means to be determined by the associations in consultation with the Department.

- **Recommendation 2:** The Department recommends that a survey of Minnesota hospitals be conducted to determine hospitals' interest level in pursuing magnet hospitals status, and what specific incentives would be most helpful in encouraging hospitals to go forward. This survey should be conducted several months after the publicity/promotional effort referenced in the preceding paragraph is launched.

- **Recommendation 3:** If the hospital survey results support this approach, the Department recommends that private and/or public funding be sought to establish a program of financial and technical assistance to potential magnet hospitals. The Department will consider developing a "magnet hospitals initiative" for submission as part of the Governor's Biennial Budget for the 2003 legislative session.

- **Recommendation 4:** Finally, the Department recommends that the Minnesota Hospital and Healthcare Partnership, the Minnesota Nurses Association and other interested professional organizations, along with the Minnesota Department of Health, formally approach the American Nurses Credentialing Center (ANCC) with proposals to create a "small facilities" magnet designation category and a "joint facilities" category for hospitals with attached nursing homes. Both of these new categories should be substantially less costly to the facility than the existing fee structure.

Introduction

Registered nurses (RNs) fill a variety of roles in health care settings, including patient advocate, health educator, direct care provider, and health care administrator. In 1999, registered nurse was the largest health care occupation in both the nation and the state with over 2.2 million jobs nationally and 44,500 jobs in Minnesota. In Minnesota and across the nation the current shortage of RNs presents a unique dilemma, especially as the demand for RNs continues to outpace the available supply of nursing professionals. In the past, the shortage of RNs could be addressed principally through an expansion of nursing education programs. Due primarily to the aging of the RN workforce, stagnant graduation trends and heightened employer demand for RNs, the current and future shortage of RNs will likely not be as easy to address. As a result, policy makers, health care employers and nursing educators have expressed concern about the state's ability to meet the demand for RNs.

In response to these concerns, the Minnesota Legislature directed the Minnesota Department of Health to examine one innovative nursing workforce approach, the Magnet Nursing Services Recognition Program, and develop recommendations for incentives that may be implemented to increase the number of magnet hospitals in Minnesota. In October 2001, the Minnesota Department of Health convened a panel of nursing workforce experts and health care providers in order to identify magnet hospital incentives. A list of panelists can be found in Appendix A. This issue brief summarizes the barriers and incentives identified by panelists and provides background information on the registered nurse shortage and the Magnet Nursing Services Recognition Program.

Background

Registered Nurse Shortage Characteristics

In the 1990s, the growth in the supply of new RN graduates has remained steady but slow. Unlike other occupations, RNs have well-defined educational requirements. When examining graduation rates, however, it is important to remember that in-state graduates do not account for all RNs in the workforce. Nevertheless, the number of graduates completing two- and four-year programs does provide one estimate of nursing program capacity and the current available

supply of new workers. In Minnesota, there are currently 24 approved programs that offer RN training either at the associate, baccalaureate or post- baccalaureate level.

While the demand for RNs has gradually increased over time, the number of individuals completing RN programs has not. Between 1984 and 1997, the number of RN graduates in Minnesota with either an associate or bachelor's degree increased by 26 percent. When considered alongside trends in the growth of RN employment and the estimates of the current demand for RNs in the labor market, these data suggest that the state's post-secondary educational system may not be keeping pace with the demand for RNs. Fortunately Minnesota's RN graduation rate has remained constant throughout the 1990s. Nationally, nursing programs have seen a drop in enrollments and graduations in the last five years.

The supply of available RNs is also affected by the composition of the current workforce. Nationally, the age structure of the active RN workforce has shifted during the past two decades - between 1983 and 1998 the average age of an RN increased by 4.5 years. This aging of the workforce has also impacted Minnesota. During the past six years, the average age of active Minnesota RNs increased by 1.5 years from 43.6 in 1996 to 45.3 in 2000. Compared to the rest of the nation, the aging of the RN workforce is more pronounced in Minnesota. On average, RNs are almost three years older in Minnesota than the rest of the nation (45.3 and 42.4 respectively in 2000). While younger nurses, those ages 35 and younger, tend to work in hospital inpatient settings, a higher proportion of RNs ages 55 and older work in educational facilities and nursing homes. In fact, 25 percent of RNs working in nursing homes are over 55 years of age.

RNs who work in urban areas of the state (the Twin Cities, St. Cloud, Duluth and Rochester) tend to be younger than their rural counterparts. Rural RNs are, on average, one and a half years older than those working in urban areas (46.4 and 45 respectively). Regions with RNs older than the state average include the southwest, north central and northeast areas of the state. The aging of the RN workforce will impact rural hospitals and nursing homes first since more nurses in these facilities will reach retirement age sooner.

While the RN workforce continues to age and the supply of new graduates has grown slowly during the 1990s, the demand for RNs has increased notably. During the 1990s the median wage for an RN increased from $14.87 in 1990 to $23.42 in 2000 - a 20 percent increase in real wages. In addition, RN employment in the state has grown by 44 percent over the last thirteen years (1986 to 1999) and is expected to increase to well over 47,000 jobs by 2008. With regard to the current level of demand, employers reported that they were trying to fill an estimated 3,000 RN openings across the state in the spring of 2001. The majority of these openings (67 percent) were in the Twin Cities seven county region. Overall, two-thirds of RN openings remained unfilled for more than two months or were considered always open by employers.

One critical consequence of the strong demand for RNs has been an increase in staff turnover. The tight labor market for RNs is currently creating incentives and opportunities for more RNs to change jobs. According to data collected by the Minnesota Hospital and Healthcare Partnership, the average quarterly turnover of RNs at Minnesota hospitals was six percent in the spring of 2001. Turnover is costly because it forces an employer to devote human and financial resources to filling positions. For example, the Mayo Clinic documented 141 RN terminations (5.5 percent of its RN workforce) in 2000. Using one calculation of the cost of turnover (150 percent for staff and 200-250 percent for managers of annual compensation per position), the Mayo Clinic estimated that it cost roughly $14,000,000 to replace the 5.5 percent of its RN workforce from 2000. [1]

Magnet Nursing Services Recognition Program Overview

The Magnet Nursing Services Recognition Program for Excellence in Nursing Services was developed by the American Nurses Credentialing Center (ANCC) in 1994 to recognize health care organizations that provide high quality nursing care and support the professional nursing practice. Nationwide, there are currently 32 facilities that have received the Magnet Nursing Services Recognition status. The only Minnesota facility to receive this distinction is the Mayo Clinic in Rochester. (The ANCC recognizes magnet long term care facilities as well as magnet hospitals. This report will deal only with magnet hospitals.)

The Magnet Nursing Services Recognition Program is based on quality indicators and standards of nursing practice as defined in the American Nurses Association's Scope and Standards for Nurse Administrators (1996). The stated objectives of the program are to:

- Recognize nursing services that utilize the Scope and Standards for Nurse Administrators (ANA, 1996) to build programs of nursing excellence in the delivery of nursing care to patients;
- Promote quality in an environment that supports professional nursing practice;
- Provide a vehicle for the dissemination of successful nursing practices and strategies among health care organizations utilizing the services of registered professional nurses;
- Promote positive patient outcomes.

Application Criteria and Process

The foundation of the Magnet Nursing Services Recognition Program is the American Nurses Association's Scope and Standards for Nurse Administrators. The applicant heath care organization provides documentation and evidence that support and verify implementation of these standards throughout the nursing service. There are no geographic or facility size constraints directly associated with applying for the recognition program. In order to apply for the recognition program, a health care organization must meet the following eligibility criteria:

- The applicant nursing service system exists within a health care organization.
- The health care organization nursing service includes one or more nursing settings with a single governing authority and one individual serving as the Nurse Administrator.
- Scope and Standards for Nurse Administrators (ANA, 1996) are currently implemented by the nursing system.
- In the five years preceding application, the applicant nursing service must not have committed an unfair labor practice as determined in a fully and finally adjudicated proceeding before the National Labor Relations Board (NLRB) or other grievance resolution body, and/or a reviewing federal, state or international court. If an unfair labor charge or grievance is pending before the NLRB or other appropriate governing body at

the time an application is being processed, no action will be taken on the application until the NLRB or an appropriate governing body finally resolves the dispute.

- Applicants for Magnet recognition are required to participate in ANA's National Database of Nursing Quality Indicators (NDNQI). This project addresses the issues of patient safety and quality of care arising from changes in health care delivery.

The application process consists of four phases. During the first phase, an applicant completes the one-page application form, submits a non-refundable payment of $1,000, and identifies an anticipated date for submission of the appraisal documents. The applicant has two years within which to submit their written appraisal documentation. In the second phase the applicant provides written documentation of how the health care organization implements the Scope and Standards for Nurse Administrators (ANA, 1996) at their site(s). The review begins after the documentation has been completed and submitted to the Magnet Program Office along with the appraisal fee (see Table 1) and program appraisers are selected and jointly approved by the health care organization. The review process can be terminated and the application terminated at any time by the appraisers if baseline minimum standards (the Core Measurement Criteria) are not met.

The third phase of the process consists of a two-day site visit. The purpose of the site visit is to verify and clarify the documentation provided to date in the application process. Site visit expenses are paid for by the health care organization and consist of travel and lodging expenses for a minimum of two appraisers plus an honorarium of $500 per day per appraiser. The second and third phases of the process are conducted by RNs with experience in quality indicators, nursing services administration, and nursing care. The fourth and final phase takes eight weeks to complete and is completed within the Magnet Program Office where the appraisers' final report and recommendations are reviewed and a decision on the recognition status of the applicant is rendered.

After four years, health care organizations must reapply to the ANCC to continue their recognition status as a magnet hospital. The appraisal fee is reduced to 40 percent of the original

fee paid by the health care organization and the application process is slightly abridged to include a revised second phase and full third and fourth phases of the application process.

Table 1: Magnet Recognition Program Fee Schedule, 2001*

Application Fee $1,000

Appraisal Fees

Acute Care Inpatient Settings

Bed Size	Appraisal Fee
100 or less	$9,300
101-299	$11,500
300-399	$20,000
400-499	$29,000
500-749	$37,500
750-949	$45,000
950+	$45,000 + 50 per bed over 949

Long-Term Care Inpatient Settings

Bed Size	Appraisal Fee
50 or less	$3,700
51-100	$4,800
101-150	$6,000
151-200	$7,000
201-350	$8,000
351-500	$10,000
501+	$10,000 + $20 per bed over 500

Appraiser Honorarium $500 per appraiser
Paid by applicant organization to ANCC after appraisers are appointed. Usually there are two appraisers per application. However, circumstances could require additional appraisers.

Site Visit Fee $1,500 per day per appraiser
Paid by applicant to ANCC when site visit dates are identified. Site visits usually require two appraisers for two full days. However, large health care organizations, health care systems, and health care organizations with multiple sites could require more appraisers and/or more visit days. In addition there are travel/lodging related expenses for the site visit.

*Effective November 1, 2000, for all applications received after that date. The fee schedule is applicable to in-patient settings in the United States of America.
Source: American Nursing Credentialing Center, Washington, D.C., 2001.

Benefits of Magnet Recognition

ANCC Magnet status is designed to recognize hospitals that "attract and retain nurses" and promote professional nursing practice. Due to some of the common organizational features, such as "non-hierarchical organizational structures, unit based decision-making processes, influential nurse executives" professional skill building, and higher nurse staffing levels, magnet hospitals enjoy higher levels of RN job satisfaction and lower levels of burnout and job related stress when compared to other like non-magnet hospitals.[2] These "magnet organizational features," in turn, strongly reinforce a magnet hospital's ability to attract and retain nurses and reduce staff turnover. In addition, the same organizational attributes that attract RNs to magnet hospitals "have been found to be consistently and significantly associated with better patient outcomes, than those of matched, non-magnet hospitals."[3] Furthermore, magnet designated hospitals also enjoy lower levels of RN staff turnover compared to non-magnet hospitals. In 2000, the median turnover rate for RNs at magnet hospitals was 7.6 percent compared to 14 percent for non-magnet hospitals.[4]

Arguably, these benefits do not come directly as the result of a hospital's magnet recognition. Instead, they tend to broadly reflect, regardless of magnet status, the implementation and continued support of "magnet organizational features" within the hospital and its nursing practice. Still, magnet hospital recognition, like other accreditation processes (e.g., JCAHO) can be used by a facility as a competitive advantage to clearly identify its quality nursing care to health care consumers and work environment to the registered nurse workforce.

Minnesota Panel Discussion of Magnet Designation

In order to better understand barriers and potential incentives for Minnesota hospitals to pursue magnet hospital designation, the Minnesota Department of Health (MDH) convened a panel discussion involving a number of nursing workforce experts and health care providers from around the state. (See Appendix A for a list of panel members.) In addition, MDH staff conducted phone interviews with five hospital administrators from geographically dispersed areas of the state. The remainder of this report summarizes the panel discussion held in late October 2001 and, where appropriate, incorporates input from the five administrator interviews.

To understand why more Minnesota hospitals have not pursued magnet hospital designation so far, the panel of nursing workforce experts and health care providers was asked to identify significant barriers that would prevent a hospital from seeking this designation. The panel identified barriers in the areas of costs, data, and existing hospital culture.

Barriers

Financial

There are numerous cost barriers to pursuing magnet hospital designation. The costs of the application fee and the appraisal process itself are high, particularly for small hospitals. The initial application fee is $1,000 per facility. Additionally, the fee for the actual program appraisal is based on the number of beds in the facility (See Table 1). For hospitals with a bed size of 100 or less, the appraisal fee from the Magnet Recognition Program Fee Schedule is $9,300. In Minnesota, 113 of our 142 hospitals have 100 or fewer beds. This represents nearly 80 percent (79.6 percent) of Minnesota hospitals. Thirty percent of Minnesota hospitals have 25 or fewer beds. Over 60 percent of Minnesota hospitals have a bed size of 50 or less (See Table 2).

Table 2: Minnesota Hospitals by Bed Count, 2001*

Bed Size	Number of Hospitals	Percent	Cumulative Percent
25 or less	43	30.3	30.3
26-50	44	31.0	61.3
51-100	26	18.3	79.6
101+	29	20.4	100
Total	142	100	

*All Critical Access Hospitals have at least 15 beds (plus up to 10 swing beds).

Source: Minnesota Department of Health, 2001.

Many of Minnesota's small hospitals seek grants from sources such as the Office of Rural Health and Primary Care for financial analysis, planning and improvements for amounts as small as

2,500 dollars. If grants are needed for hospital activities costing less than $3,000, the $1,000 application fee plus the $9,300 appraisal fee would be well out of the range of many small hospitals. In addition, as part of the Magnet Recognition program, there is an appraiser honorarium to be paid by the applicant organization. For two appraisers, this would add a cost of $1000 to the total to be paid to apply for this program. Also, a site visit is part of the appraisal process, and the site visit fee is $1,500 per day per appraiser, with a minimum of two days and two appraisers. Clearly, $17,300 plus travel and lodging expenses for appraisers is a high entry cost for a program designation for hospitals of the size most common in Minnesota.

Hospitals seeking magnet designation will incur other costs as well. These include staff costs to assure that policies and procedures within the hospital are adequate to meet designation standards, plus the costs to prepare application materials. Since many hospitals are already facing staff shortages, it may be impossible to pull existing staff from their current duties to work on these tasks, and the cost of hiring staff to do this may be prohibitive.

The panel suggested that while short-term contract staff might be able to assist in preparing application materials, it is important to remember that this process is about much more than putting together an application. One panel member noted "this is not an improvement program; it's a recognition program. You can't just put the application together in order to apply for designation; it has to be the culture that exists. It can't be put together as a short-term project. The designation reflects that culture that has been grown at a facility over time." One panel member suggested that it might be necessary to increase the overall RN staffing levels to meet program eligibility criteria.

When asked about financial barriers for this program, administrators expressed a range of responses regarding the cost of the magnet hospital application and appraisal process. One administrator at a small rural hospital felt the cost made the program "totally out of reach" for a facility of his size. A second administrator at a similarly sized hospital stated that the cost was very high, but more importantly, the value of the program to a hospital of that size in rural Minnesota had not been demonstrated. He felt that the cost of the program could only be evaluated once the potential benefits could be demonstrated for hospitals in communities that

don't have a lot of the "pull factors" that attract nurses to other locations, such as Rochester or the Twin Cities.

Other administrators did not see the cost of the designation process to be prohibitive. The largest facility surveyed said that the cost would not be a barrier and that their facility would "just write a check" if they elected to pursue designation. One administrator from a smaller facility said "the cost is something you deal with if it is a goal of the organization." From these interviews, it appears that financial incentives for the magnet hospital program would be most beneficial to smaller hospitals, but they may not be sufficient for those hospitals to make the decision to pursue designation.

Patient and Organization Data

A further barrier to the designation of more magnet hospitals in Minnesota is the requirement of the program for data, principally patient health outcome data. Much of the data needed for magnet hospital designation is patient satisfaction data. The panel felt that some hospitals, particularly smaller ones, might not have the staff and expertise to develop and maintain the necessary information systems.

One panel member felt that the designating organization, ANCC, was "using the database as a hammer. If you want to be a magnet, you have to be in their database." However, she felt that she is bound by institutional rules about what she can share with organizations such as ANCC. She felt that the peer review process might be compromised by the data requirements of the magnet hospital program. Overall the panel expressed similar concerns that many hospitals currently would not have the level of data required for designation. In addition, there may be problems even for those hospitals that have created or could create such data systems, in terms of conflicts with peer review and other credentialing processes.

The hospital administrators expressed fewer concerns about data than did the panel. Most administrators interviewed said that ongoing data collection regarding quality and patient satisfaction is a routine function at their facilities. If new data fields or items had to be added to existing data reports, this did not seem to be a major barrier, whether data were collected in-

house or were analyzed and reported by an outside vendor. The area that was most problematic for administrators was that of data privacy if other than aggregate data were to be shared with the credentialing body. Issues of patient confidentiality and data privacy were primary.

Organizational Culture

Another barrier described by the panel is hospital culture. The group indicated that for many hospitals, a culture change would have to take place in order for magnet hospital designation to be possible. A primary focus was the need for a nurse administrator within the hospital. In addition to the need to have a nurse administrator to meet eligibility requirements, the panel concluded that this individual has to be a "champion" for seeking magnet designation for this process to even be possible. This nurse administrator must have the autonomy to create an environment where professional nursing practice is valued and supported over time. Some panel members felt that currently "there is a lack of recognition of professional nursing and how important it is" in some hospitals. "A culture change is required to value nursing; organizational culture is a bigger barrier than application and capacity building costs." Panel members expressed concerns that "large organizations have trouble with recognition of the value of nursing" and "small rural hospitals thought that it was unmanageable for a facility of that size." One panel member doesn't think size matters. "Really small hospitals may have trouble getting resources to put the application together if they didn't have expertise or resources because they're so busy with other things. The organization could hire someone to assist staff with the completion of the application; the change in turnover would pay for the application process itself."

A related concern deals with the time that the designation process takes. Panel members suggested that eighteen months might be a typical length of time to get through the designation process. There were concerns that hospitals that started the process may not be able to complete the application if key staff left during the eighteen-month period. This fear was particularly acute with regard to the possible mid-process departure of a supportive hospital administrator. Similarly, the nurse administrator needs to be committed to staying through the process. Hospitals with staff that understand the various steps involved in the application process and feel valued as professionals throughout the process, and with a CEO and a nurse administrator who

are champions for the process, will have the best chance of passing the rigorous designation process.

Most of the hospital administrators felt that the culture in their hospitals would be conducive to the magnet hospital program. One administrator felt they "have a culture that would be nurturing" and that their head of nursing "has a passion for nursing, leadership, and mentoring ability" while another said that his nursing administrator "has a very collaborative leadership style" that would fit well with the magnet program. A bigger barrier for administrators is the number of activities that are already occurring in their facilities, and the fear that with so many activities on their plates, hospitals would not have enough staff and internal resources to take on another activity of this scope. Administrators mentioned current quality projects, construction activities, a patient safety initiative, a service excellence program, and other projects that are currently on their schedules. Clearly, the magnet program fits into administrators' current views as their facilities pursue activities related to quality, patient safety, and excellence. The hospital cultures appear conducive to this program but incentives would be needed for them to add another program onto their schedules. To do this, the value of the designation must be demonstrated, perhaps through data and descriptions of benefits experienced by existing magnet hospitals.

Potential Incentives

The panel of nursing workforce experts and health care providers and the hospital administrators interviewed for this report discussed a number of potential incentives that might encourage more Minnesota hospitals to seek magnet designation. In general, the group felt it would be necessary to do a better job of "getting the word out" about the magnet hospital program, especially to hospital administrators, in order to pique the interest of facilities in applying for magnet designation.

It is important to note that, when better understood and more fully communicated, the inherent benefits of the magnet hospital program may be the best incentive there is for more hospitals to seek this designation. As was discussed earlier in this report, magnet hospitals tend to enjoy

higher levels of RN job satisfaction and lower levels of burnout and job-related stress than do non-magnet hospitals. These features in turn lead to higher RN recruitment and retention rates and lower turnover rates for magnet hospitals. Turnover has very real costs in terms of lost productivity and dollars spent on recruitment and training of new staff. Given the current and projected RN shortages facing many Minnesota hospitals, these workforce factors may be incentive enough for many Minnesota hospitals to seek magnet status. On the other hand, hospitals that invest the time and effort needed to become "magnet-like" facilities, with many of the features of a magnet hospital but without the formal designation, would likely enjoy many of the same benefits without the additional cost of the designation process.

Encouraging more Minnesota hospitals to pursue magnet designation does raise the troubling issue of regional competition for limited numbers of RNs. Currently, anecdotal evidence suggests that hospitals and other facilities located in close proximity to one another are competing, through higher wages, for the same limited pool of RNs. Since a magnet hospital in a given area would likely have a recruitment/retention advantage over its non-magnet neighbors, it is important for the State to take this regional labor market effect into account when considering offering financial and other incentives to hospitals to pursue magnet designation.

The panel and the individual hospital administrators discussed various financial and non-financial incentives that could be offered to hospitals to encourage them to seek magnet status. Following is a summary of the incentives discussion.

Financial

The panel identified several financial incentives to increase the number of magnet hospitals in Minnesota. These include:

- Grants for magnet hospital designation preparation, to assist with policy and procedure review and development, changes in organizational operations and so forth;
- Assistance with costs of the designation process, including the appraisal fee, site visit expenses, and appraiser honoraria.

First, the panel suggested that direct financial assistance through grants could be made to hospitals to help them prepare for and participate in the application and designation processes. This could include helping the facility to review and take steps to change its policies, procedures, and most significantly in terms of cost and time commitment, its organizational culture. Hospitals might then decide to pursue designation, and an additional grant program might be developed to assist with the costs of the appraisal process itself. The panel felt that there is value to an institution in preparing for the magnet designation process, even if designation is not achieved. Also, financial assistance for aspiring magnet hospitals could be added as eligible activities to the state's Rural Hospital Planning and Transition Grants Program (Minnesota Statues 144.147) or other existing grant programs. Additionally, magnet hospitals could be treated as preferred internship sites for purposes of the state's Summer Health Care Internship Program (Minnesota Statutes 144.1464) and other health workforce development programs.

For hospital administrators, the anticipated benefit of financial incentives varied across facilities. For the smallest rural hospitals, financial incentives would likely be necessary because of the magnitude of the cost of the magnet hospital application and appraisal process. Grants for application assistance were mentioned as one financial incentive. As the size and financial stability of the hospital increases, it appears the anticipated benefit of a financial incentive declines in value. For the largest hospital surveyed, financial assistance would not be a strong incentive to seeking magnet designation. Like the panel, the administrators felt that the financial incentives would be helpful for some hospitals, but may not be sufficient for hospitals to seek magnet designation.

In addition to direct financial assistance, the panel also suggested that the ANCC could be approached regarding the fee structure categories based on facility bed sizes. Since Minnesota has so many facilities with bed sizes much smaller than 100, panelists felt that ANCC might be willing to create additional categories below the 100 bed threshold that would be associated with a reduction in fees for smaller facilities. Clearly, a significantly lower fee for small hospitals would make the program much more attractive. Since Minnesota has a number of hospitals with attached nursing homes, it was suggested that ANCC be approached to entertain the possibility of a joint hospital/nursing home designation, with a combined fee that would be less than the

sum of the two separate fees. This would help to increase the number of magnet long-term care facilities as well, which are extremely rare across the United States. The panel felt that increasing the number of nurses attracted to a facility through the magnet program would help both the hospital and the nursing home in such attached facilities.

Technical Assistance and Information Sharing

The panel identified hospitals' need for non-financial assistance through:

- Provision of technical assistance for completing the application process,
- Consultation on the development and implementation of outcomes information systems, and
- Creation and sharing of information designed to inform nurses and hospital administrators of the magnet recognition program.

The panel identified technical assistance to facilities interested in pursuing magnet designation as a much-needed incentive. One panelist said of the magnet designation process: "it's knowing how to start that is hard." Specific technical assistance resources could include assistance in filling out the many forms for the application process, helping the organization "figure out how to approach the cultural change" and other help from those who have experience in the magnet hospital program.

The panel brainstormed the idea of Minnesota as a "Magnet State" in which pursuit of designation would not be addressed only at the hospital level, but that hospitals would work with educational institutions, the Minnesota Department of Health, professional organizations such as the Minnesota Nurses' Association, the Minnesota Hospital and Healthcare Partnership, and others to move toward designation of many magnet facilities statewide. By taking this larger view, it might be possible to reduce regional competition in hiring, and also reduce the likelihood of leaving some hospitals behind if they do not achieve magnet designation. It was suggested that a cohort approach might be used, in which a number of hospitals expressing an interest in magnet designation would go through the application process at the same time. This cohort could then, as they encountered challenges in the application and designation processes, receive assistance from the designated technical assistance agency, and could also provide

mutual assistance and support to one another. In addition, after these hospitals receive their designation, they could become resources for other facilities in the process. By promoting Minnesota as a Magnet State, a more unified approach to pursuing designation could be implemented, regional competition might be reduced, and the attractiveness of nursing opportunities across the state could be enhanced.

A second possible incentive would be consultation on information gathering and sharing, and system development. Many hospitals, particularly small rural hospitals, do not have the capacity to design and implement complex outcomes data systems. Providing assistance in designing and implementing such a system was seen as a way of making the possibility of magnet hospital designation more realistic. This system could be shared by facilities that are seeking designation.

The most straightforward magnet hospital incentive suggested by the panel was wider and more comprehensive dissemination of information about the program. Several members of the panel felt that this program is much more widely understood on the East Coast than it is in Minnesota or in the Midwest in general. Increasing awareness and education about the program was seen as the first step in improving the odds that a facility would pursue magnet hospital designation. Also, figures cited by group members indicated that staff turnover at Magnet Hospitals was much lower than at comparable non-magnet facilities. Broader dissemination of this type of information would likely encourage hospitals to look at designation as a nursing recruitment and retention tool.

Like the panel, all of the hospital administrators interviewed saw technical assistance and information sharing as important strategies. Disseminating information about the magnet hospital program was felt to be important in bringing the program to more facilities in Minnesota. One administrator felt that professional organizations like the Minnesota Hospital and Healthcare Partnership (MHHP) would be a "good conduit" for sharing information about this designation program. Additionally, most of the administrators would appreciate technical assistance in preparing the hospital for the application process, and in preparing the actual application itself. Several administrators felt that having a person who was expert in magnet designation and operations available to provide assistance would be most helpful. Several felt

that this position should be located in a state agency, such as the Minnesota Department of Health, for it to be most accessible to hospital staff.

In terms of the future, one administrator felt that the best way to expand this program's reach in Minnesota would be to help a few hospitals gain magnet designation in the near future. These hospitals could then use their designation in their marketing activities to make the designation better known around the state, and these hospitals could act as resources for hospitals seeking designation in the future. These ideas support the panel suggestion that a cohort of hospitals be assisted through the process to help in its establishment in Minnesota. This could be done in ways that reduce regional competition and help support the "Magnet State" concept.

Ongoing Incentives to Continue in the Magnet Hospital Program

In addition to the incentives that could assist facilities in pursuing magnet designation, the panel looked forward to incentives that could help to maintain magnet facilities in the future, once they have received designation. These ideas included:

- Eligibility for enhanced reimbursements from programs such as Medical Assistance or MinnesotaCare;
- State efforts to encourage federal legislation that would promote nursing, such as the Clinton-Smith bill to provide grants to health care facilities and training institutions for demonstrating best practices in nursing and the Lieberman/Ensign bill to distribute funds to hospitals to improve the quality of the work environment and to initiate recruitment and retention programs.

The panel suggested that magnet hospitals could be eligible for enhanced reimbursements from various programs, such as Medical Assistance or MinnesotaCare, based on their designation status. For example, the state might want to consider offering magnet hospitals cost-based reimbursement through the Medical Assistance program.

Panelists also identified pending federal legislation, such as the Clinton-Smith bill and the Lieberman/Ensign bill that would encourage the implementation of the ANCC's criteria for

magnet designation. The Clinton bill would authorize three-year grants to health facilities to demonstrate best practices related to the goals of:

- Improving nurse retention and satisfaction;
- Promoting collaboration and communication among nurses and other health care professionals;
- Improving nurse participation in clinical decision-making processes;
- Improving opportunities for nurses to continue their education and receive organizational recognition;
- Enhancing the measurement of nurse-sensitive patient outcomes;
- Promoting a balanced work-life environment.

The bill would require the Agency for Healthcare Research and Quality (AHRQ) and the Health Resources and Services Administration (HRSA) to conduct annual surveys of these demonstrations and report to Congress on best practices for nursing care.

The Lieberman bill would authorize grants to hospitals to improve the quality of the work environment and to initiate recruitment and retention programs. To qualify for funds, facilities must demonstrate:

- Nurse participation in the development of nursing-sensitive outcomes measurement,
- The inclusion of staff nurses and nurse leaders in decision-making processes,
- The formation of a nurse retention committee that includes the participation of staff nurses in the development of retention initiatives,
- The development of a 3-12 month nurse residency training program for recent graduates and returning nurses;
- Facility support for continuing education for nurses.

In addition, funds would be set aside for scholarships for acute care nurses to enter RN to BSN programs. In return for this support, students would be required to work as a nurse in the facility that sponsors them for an amount of time at least as long as their scholarship.

A compromise version of the two bills was incorporated in the Nursing Employment and Education Development Act (S. 721) and the Nurse Reinvestment Act (S. 1597) when they passed out of committee on November 1, 2001.

The panel felt that Minnesota should support federal legislative initiatives to improve the nursing environment. These bills represent the kinds of initiatives that the panel felt are needed to promote best practices in nursing and to initiate recruitment and retention activities.

Summary and Recommendations

Potential incentives discussed earlier in this report for increasing the number of magnet hospitals in Minnesota fall into three broad categories: financial incentives, technical assistance, and information dissemination.

- **Financial incentives** could be in the form of grants to hospitals to help cover the costs of consulting resources, filling out forms and compiling documentation needed for the application process, developing and maintaining required data systems, and paying the actual magnet hospital application and site visit fees.

  Additional financial incentives could be in the form of a reimbursement bonus for hospitals that achieve magnet status. For example, the state might want to consider offering magnet hospitals cost-based reimbursement through the Medical Assistance program.

  A third type of financial incentive could be to offer preferential treatment to magnet hospitals (or those considering becoming magnet hospitals) in administering other state financial assistance programs. For example, magnet hospitals could be treated as preferred internship sites for purposes of the state's Summer Health Care Internship Program (Minnesota Statutes 144.1464) and other health workforce development programs. Application development and other activities facilities need to undertake in

order to become magnet hospitals could be added as eligible activities to the state's Rural Hospital Planning and Transition Grants Program (Minnesota Statues 144.147).

Finally, the Magnet Hospitals Panel brought together by the MDH to discuss potential incentives discussed the possibility of approaching the ANCC (the magnet hospitals credentialing organization) about the possibility of creating a special, less expensive and possibly less burdensome "small facilities" category for very small hospitals wishing to pursue magnet designation. One member of the panel had actually approached the ANCC with this idea, and was told that the ANCC would consider it. If Minnesota were to formally approach the ANCC with this idea and ask to participate in the development of criteria for the "small magnet hospitals" grouping, additional incentives could be built in to encourage more of our state's many small rural hospitals to participate. The panel also supported the idea of approaching ANCC with a proposal to establish a joint facility designation for hospitals with attached nursing homes.

- **Technical assistance**. The Office of Rural Health and Primary Care currently offers technical assistance to health care providers in rural and underserved urban areas, including hospitals applying to become Critical Access Hospitals. Office staff pay informal visits to facility staff, hospital boards, and other groups who are requesting information on the Critical Access Hospital program. The purpose of the visits is to brief them on the requirements of the program, offer advice and assistance on changes the facility will need to make in order to qualify for the program, and conduct "mock surveys" to help facility staff prepare for the formal survey to be conducted later by MDH's Facility and Provider Compliance staff. A "Magnet Hospitals Technical Assistance" program could be established to provide similar types of assistance to hospitals considering pursuing the magnet designation.

- **Information dissemination**. The Magnet Hospitals Panel and a number of the hospital CEOs interviewed for this report agreed that, in general, little is known in Minnesota about magnet hospitals. While the program has existed for a number of years, it has been slow to take hold in Minnesota and the rest of the Midwest. Since the benefits of magnet

designation seem clear, it seems likely that if more hospital administrators, nurse executives, and hospital boards clearly understood the program itself, the application process, and the potential benefits to the facility, more facilities would choose to seek magnet designation.

Recommendation 1:

The Minnesota Department of Health recommends that the Minnesota Hospital and Healthcare Partnership, the Minnesota Nurses Association and other interested professional organizations, in consultation with the Minnesota Department of Health, immediately plan and undertake an effort to publicize and promote the magnet hospitals program within the state. This could include publishing informational materials and newsletter articles, making magnet hospital information available at conventions, conferences, and other professional gatherings, and other means to be determined by the Associations in consultation with the Department.

Recommendation 2:

The Department recommends that a survey of Minnesota hospitals be conducted to determine hospitals' interest level in pursuing magnet hospital status, and what specific incentives would be most helpful in encouraging hospitals to go forward. This survey should be conducted several months after the publicity/promotional effort referenced in the preceding paragraph is launched.

Recommendation 3:

Pending the outcome of the hospital survey, the Department recommends that private and/or public funding be sought to establish a program of financial and technical assistance to potential magnet hospitals. The Department will consider developing a "magnet hospitals initiative" for submission as part of the Governor's Biennial Budget for the 2003 legislative session.

Recommendation 4:

Finally, the Department recommends that the Minnesota Hospital and Healthcare Partnership, the Minnesota Nurses Association and other interested professional organizations, along with the Minnesota Department of Health, formally approach the ANCC with proposals to create a "small facilities" magnet designation category and a "joint facilities" category for hospitals with

attached nursing homes. Both of these new categories should be substantially less costly to the facility than the existing fee structure.

[1] Doreen Frusti, "Magnet Status: A New Approach to the Nursing Shortage," Minnesota Organization of Leaders in Nursing (MOLN) Conference, Fall 2001.
[2] Linda Aiken, Donna Havens and Douglas Sloane, "Magnet nursing services recognition programme," *Nursing Standard*, 8 March 2000, 41-42; Heather Lashinger, Judith Shamian and Donna Thomson, "Impact of Magnet Hospital Characteristics on Nurses' Perceptions of Trust, Burnout, Quality of Care, and Work Satisfaction," Nursing Economics, September-October 2001, 209-212, 216.
[3] Linda Aiken, Donna Havens and Douglas Sloane, "Magnet nursing services recognition programme," *Nursing Standard*, 8 March 2000, 42.
[4] Doreen Frusti, "Magnet Status: A New Approach to the Nursing Shortage," Minnesota Organization of Leaders in Nursing (MOLN) Conference, Fall 2001.

Appendix

Minnesota Department of Health
Office of Rural Health and Primary Care

Magnet Hospitals Work Group

Mary Absolon
Program Manager
Minnesota Department of Health
Facility & Provider Compliance
Licensing and Certification Program
85 E. Seventh Place, Suite 300
P.O. Box 64900
St. Paul, MN 55164-0900

Christine Bakke
Administrative Fellow
St. Cloud Hospital
1406 Sixth Avenue North
St. Cloud, MN 56303-1901

Elizabeth Biel
Director, Health Policy
Minnesota Hospital and Healthcare Partnership
2550 University Avenue West, Suite 350S
St. Paul, MN 55114-1900

Carol Diemert
MNA Nursing Practice Specialist
Minnesota Nurses Association
1625 Energy Park Drive
St. Paul, MN 55108

Sandra Edwardson, PhD, RN
Dean & Professor
University of Minnesota
School of Nursing
6-101 Weaver-Densford Hall
308 Harvard Street SE
Minneapolis, MN 55455

Doreen Frusti, MSN, MS, RN
Chair, Department of Nursing
Mayo Clinic
200 First Street SW
Rochester, MN 55905

Lynn Jaycox
Clinical Manager
Immanuel-St. Joseph/Mayo Health System
18587 Maple Haven Lane
Mankato, MN 56001

Elizabeth Sether
Co-Chair Minnesota Colleagues in Caring
State Council on Nursing
Nurse Consultant/Policy Analyst
Minnesota Health & Housing Alliance
2550 University Avenue West, Suite 350S
St Paul, MN 55114-1900

Peggy Sietsema, MPH, RN, CNAA
Associate Administrator, Clinical Services
Rice Memorial Hospital
301 Becker Avenue SW
Willmar, MN 56201

Susan Stout
Governmental Affairs Specialist
Minnesota Nurses Association
1625 Energy Park Drive
St. Paul, MN 55108

Marty Witrak, PhD, RN, CS
Chair, Department of Nursing
Chair, Health Sciences Division
The College of St. Scholastica
1200 Kenwood Avenue
Duluth, MN 55811-4199