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Accreditation of Healthcare Organizations

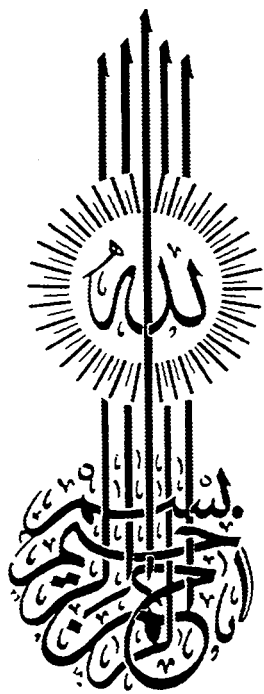
The What, the Who and the How?

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Accreditation of Healthcare Organizations: The What, the Who and the How?

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Abstract. Because of the new interest in accreditation on behalf of patients, the success of health care providers has become increasingly dependent on accreditation. Health care agencies of all types and settings are seeking accreditation, from surgery clinics to multi-specialty group practices, hospitals, health maintenance organizations, birthing centers, college and university health services, pain management clinics, and faculty medical practices. No type of health care provider is immune to the approval of accreditation agencies. Various inquiries are raised however, about what we mean by the term accreditation? Who are the accrediting bodies? What kinds of standards are out there for accrediting a health care provider? What are the factors involved? How can a health care provider pass the stringent requirements of these agencies? What are steps for pursuing accreditation?

Therefore, the best way to answer these questions is to go to the source, to the accreditation agencies themselves. This paper will focus on four of the most renowned agencies. Each one has its own definition, stressing various aspects to accreditation. But each, operates out of a main theme to improve the quality of health care. The paper also describes the structure, process, and the methodology for pursuing accreditation as well as the perceived benefits and challenges of accreditation of health care organizations.

Introduction

Millions of patients receive high as well as low quality health care services. The United States for example has many of the world's finest health care professionals, academic health centers, and other health re-

search institutions. However, too often, the quality of care provided to patients is substandard. Too often, patients receive excessive services that undermine the quality of care and needlessly increase costs. At other times, they do not receive services that have proven to be effective at improving health outcomes and even reducing costs (NCQA 2000).

Poor quality care leads to sicker patients, more disabilities, higher costs, and lower confidence in the health care industry. There is great potential to improve the quality of the health care system, and there is widespread interest among representatives in the health care system to make these improvements.

Consumers want understandable and reliable information to help them make critical decisions about their health care (Al-Assaf, 1998). Most individuals consider it very important to know how well their health plan cares for members who are sick, catches health problems at an early stage, and keeps members as healthy as possible. Private and public purchasers have also demonstrated that they want more information about the quality of the care they purchase for their employees, their dependents and beneficiaries as well as new strategies to improve it. Many private purchasers are developing quality improvement programs, report cards, and other measurement tools to help assure that they can purchase health care based on quality, not just cost and benefits (Al-Assaf and Schmele, 1993). Efforts have emerged to measure and report on health care quality that have begun to provide consumers and purchasers the information they need to purchase quality health care and to enable health professionals and others to develop targeted strategies to improve care. Businesses as well as government agencies are working with health care providers, health insurers, health plans, accreditation organizations, labor unions, and others to encourage the development of these efforts.

While there has been a patchwork of successful efforts to improve health care quality, the current system leaves many gaps, and in many other cases is redundant. Moreover, there is no mechanism to share best practices and successful strategies; many purchasers simply do not have the information they need to assure they can purchase health care on the

basis of quality, and not just what it costs or what it covers (Leiberman, 1999). Therefore, it is believed that a well designed system of accrediting health care organizations would most inevitably provide an objective mechanism to assess quality, set standards, monitor progress and improve care (NCQA, 2000; AAAHC, 2000; JCAHO, 2000; URAC, 2000).

Purpose of the Research

The purpose of this research is to analyze and review the current accreditation systems available in the United States and to examine the accreditation process as a whole. To do so, it is important to point out here that the method of the study is descriptive in nature.

Definition of the Concept

Accreditation is a rigorous and comprehensive evaluation process through which the accrediting organization assesses the quality of the key systems and processes that make up a health plan (JCAHO, 2000). Accreditation also includes an assessment of the care and service plans that are delivering in important areas such as immunization rates, mammography rates and member satisfaction (NCQA, 2000).

There are many accreditation agencies, each one, with its own requirements, set out to determine the level at which a managed health care plans, clinics and other providers of health care, such as hospitals or nursing homes. The purpose of accreditation is to give reviews to examine the process and procedures in place for delivering care. These various agencies have set out to make certain that the health care provided is the best that can be offered, and considering the importance of receiving good care, they are imperative for the best service to patients (Gonen and Probyn, 1996).

The importance of accreditation has increased with consumer awareness. It is much more common that someone will check into the level at which a hospital operates than it was just a few years ago. According to the Accreditation Association for Ambulatory Health care (AAAHC, 2000), "In recent years, patients are increasingly knowledgeable about

accreditation and its implication of quality care. Payers are increasingly demanding that providers be accredited. Managed care plans require accreditation of providers in order for the managed care plans themselves to obtain accreditation.”

Because of this new interest in accreditation on behalf of patients, the success of health care providers has become increasingly dependent on accreditation. All types of health care agencies seek this accreditation, from surgery clinics to multi-specialty group practices, health maintenance organizations, birthing centers, college and university health services, pain management clinics, and faculty medical practices. No type of health care provider is immune to the approval of accreditation agencies. Various inquiries are raised about what we mean by the term accreditation? What kinds of standards are out there for accrediting a health care provider? What are the factors involved? How can a health care provider pass the stringent requirements of these agencies? The best way to describe it would be to go to the source, to the accreditation agencies themselves. For the scope of this study, I will focus on 4 of the most renowned agencies. Each one has its own definition, stressing various aspects to accreditation. But each operates out of a main theme to improve the quality of health care.

According to the National Committee on Quality Assurance (NCQA, 2000), known as the primary accrediting agency for managed health care plans, accreditation is “a voluntary process through which an ambulatory health care organization is able to measure the quality of its services and performance against nationally recognized standards.” The most significant item to note is the above definition is the use of the word “voluntary”. It is not forced upon health care providers to receive accreditation, but because of consumer awareness, it is in the best interest of a health care provider to seek accreditation.

The AAAHC (2000) defines accreditation as “a rigorous and comprehensive evaluation process through which agencies assess the quality of the key systems and processes that make up a health plan.” This definition stresses the rigors and comprehensiveness of the evaluation.

The Utilization Review Accreditation Commission (URAC, 2000), an umbrella organization of the AAAHC began in 1990 to accredit review firms and has branched out to accredit other health care organizations. Its definition of accreditation is “a process ensuring health care organizations have addressed quality in their structure and operations.” Here, the item that is stressed is quality.

The Joint Commission on Accreditation of Health Care Organizations, JCAHO (2000), accredits about 18,000 various health care agencies, it is one of the most highly recognized accreditation agencies in the United States. JCAHO defines accreditation as a process through which “safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations is improved.”

JCAHO emphasizes the importance the improving the health care agency, regardless of the level or quality at which they operate.

The above definitions give the main concept of accreditation. Each of the four agencies listed: AAAHC, NCQA, URAC, and JCAHO have various ways of defining accreditation. The integrated definition for accreditation is the improvement and definition for the quality of health care through a voluntary, rigorous and comprehensive process of evaluation. Each agency is on a quest to improve the quality of the standards by which health care providers operate. AAAHC (2000) adds a new dimension to the concept of accreditation, “The true value of accreditation, however, lies in the consultative and educational process that proceeds the awarding of the certificate. It is the self-analysis, peer review, and consultation that ultimately helps an organization improve its care and services.”

Accreditation is a voluntary process through which a health care organization is able to measure the quality of its services and performance against nationally recognized standards. The accreditation process involves self-assessment by the organization as well as a thorough review by expert surveyors who are themselves practicing health care professionals.

The accreditation certificate is a model to others that an organization is committed to providing high quality care and that it has demonstrated its commitment by measuring up to high standards. The true value of accreditation, however, lies in the consultative and educational process that proceeds the awarding of the certificate. It is the self-analysis, peer review, and consultation that ultimately helps an organization improve its care and services (JCAHO, 1987).

What are accreditation standards?

The standards describe organizational characteristics that the accrediting organization believes are essential to high quality patient care (JCAHO, 1999). They relate to such areas as quality of care and quality management and improvement, clinical records, pharmaceutical services, facilities and environment, governance, administration, and professional development.

The standards have been developed over a period of more than 50 years by individuals presenting the highest levels of achievement in clinical practice and health care management (Gonen and Probyn, 1996). The standards are by definition dynamic and changing as medicine and health care change to reflect the highest levels of care.

Who are the accrediting organizations?

- NCQA
- JCAHO
- AAAHC
- URAC

NCQA (2000) is an independent, not-for-profit organization whose stated mission is to evaluate, report on, and accredit all U.S. managed care organizations. At present, almost 90 percent of all health insurance plans and eight states use its performance measurement tool, the Health Plan Employer Data and Information Set or HEDIS 3.0 to satisfy quality care requirements. For additional background, read Inglehart's 1996 report in NEJM on the National Committee for Quality Assurance.

NCQA's image map has a physician and administrator shaking hands amid the many disparate groups served by its Web site: government, health care organizations, employers and unions, consumers, health care providers, NCQA teams, and researchers. All these groups enter fundamentally the same NCQA database of status reports, articles about NCQA, and information on its conferences and products. Missing are any introductory articles explaining quality medical care for patients, physicians, or even health care administrators, aside from one quick article for consumers shopping for health plans. The Accreditation Status will return a list of local health plans by city and/or state, but avoid the search engine if checking the status of a specific plan and scan the list of available reports instead. This is limited information at best; the real database of comparative information, Quality Compass reports for 226 health plans, is available at a rather steep price. Articles regarding NCQA's background and goals are written from a consumer's perspective but are important reading for physicians and other health care professionals, as is the 1996 Annual Report, which discusses future plans and addresses several performance and outcome issues mentioned in the introduction. Other recommended resources: scroll down the Government Page and peruse News for articles and press releases on NCQA and its interactions with other organizations. NCQA is on the move.

NCQA's major rival is no slouch either. JCAHO is an independent, not-for-profit organization that evaluates and accredits more than 18,000 U.S. hospitals, networks, home care organizations, long term and behavioral health care facilities, laboratories, and ambulatory care services. ORYX is JCAHO's new quality initiative that will integrate the use of outcomes and other performance measures, such as JCAHO's Indicator Measurement System (IMSsystem), into the accreditation process. To provide a continual source of approved indicators for performance measure systems, JCAHO is creating the National Library of Healthcare Indicators (NLHI), a catalog of indicators applicable to ongoing quality improvement efforts related to the accreditation of health care organizations. The first NLHI publication will include measures from the US

Agency for Healthcare Research and Quality, AHRQ, (presumably Conquest, below), NCQA, Northwestern University, Primary Care Outcomes Research Institute, and Kaiser Permanente, among others.

JCAHO's (2000) straightforward Web site is in a graphic menu-within-menu format, although it also occasionally uses frames. The main menu displays sections for news, information about the organization and its publications, educational conventions, and multimedia products for sale. The other sections contain interesting background but most physicians will want to click on Performance Measurement, the section housing information on Oryx, IMSystem, RFI (instructions for those who wish to place a Request For Indicators), and NLHI. Government Relations discusses JCAHO's relationship to HCFA and other government agencies, and concludes with a 1996 subcommittee testimony before the House of Representatives on accreditation standards for managed care organizations. (For a different perspective on the same topic, compare it with American College of Physicians president William Reynolds, MD's testimony to a Senate committee on Federal Initiatives on Quality of Care).

Accredited organizations may apply for the first Ernest A. Codman award honoring excellence in use of performance measures. As with NCQA, there is virtually nothing on the management philosophy, statistics, historical perspective, practical guidance, or documentation explaining or supporting quality assurance, quality indicators, or performance measures. However, JCAHO does offer Resources, a bibliography of recent articles from the top health management journals divided into topics. Exactly what portions are free and for how long are unclear (Pinker, 2000).

The Accreditation Association for Ambulatory Health Care (AAAHC, 2000) was incorporated in 1979 as a non-profit 501(c)3 in the State of Illinois, but its history spans more than twenty-five years of independent and cooperative efforts by many national organizations, all dedicated to high quality ambulatory health care.

The AAAHC is a leader in ambulatory health care accreditation

and serves as an advocate for the provision and documentation of high quality health services in ambulatory health care organizations. This is accomplished through the development of standards and through its survey and accreditation programs.

As the original multidiscipline accreditation organization to focus exclusively on ambulatory health care, the founders of AAAHC were both visionary and pioneering. The AAAHC simultaneously recognized and embraced ambulatory care and challenged this newly emerging modality to meet rigorous standards for self-improvement and credibility.

The AAAHC Standards Handbook has been revised several times in recent years. The revisions of its nationally recognized standards reflect the experience, knowledge, and wisdom gained over the years by AAAHC surveyors, staff, and accredited organizations, and through the review and consultation by many interested health care providers throughout the country. AAAHC accreditation standards are under constant surveillance by our organization to ensure their continued relevance. They are revised when necessary to maintain value and to reflect the rapid changes in health care, all while remaining grounded in our fundamental commitment to high quality health care.

AAAHC is dedicated to educating providers in quality assurance and accreditation standards and procedures. In addition to providing education programs and presentations at major ambulatory health care meetings each year, AAAHC implements its own full-length educational sessions several times throughout the year.

Although change is an inherent part of its philosophy, AAAHC's basic principles remain firmly intact. AAAHC intends to continue its tradition of using physicians, administrators, and other health care professionals who are actively involved in ambulatory health care to conduct its accreditation surveys.

Since its founding, AAAHC has conducted hundreds of accreditation surveys of all types of ambulatory care organizations including ambulatory surgical facilities, college and university health centers, single and multi-specialty group practices, and health networks. Approximately

1100 organizations nationwide are currently accredited by the AAAHC.

The core standards developed and used by the AAAHC during its accreditation process include: Rights of Patients, Governance, Administration, Quality of Care, Quality Management & Improvement, Clinical Records, Professional Improvement, and Facilities & Environment. As the lead standard of the AAAHC's Accreditation Handbook of Standards, the Rights of Patients standard sets the tone for all remaining standards. This standard underscores the very essence of the accreditation process which is to determine that health care organizations are positively addressing essential elements to ensure the rights of patients and to provide the highest level of care possible. Throughout the AAAHC standards, issues relating to aspects of quality assurance, quality measurement and patient rights are addressed.

URAC (2000), Utilization Review Accreditation Commission (also known as the American Accreditation HealthCare/Commission) is a 501(c) (3) non-profit charitable organization founded in 1990 to establish standards for the managed care industry. URAC's broad-based membership includes representation from all the constituencies affected by managed care - employers, consumers, regulators, health care providers and the workers' compensation and managed care industries. Member organizations of URAC participate in the development of standards, and are eligible to sit on the Board of Directors.

URAC offers nine different accreditation programs for managed care organizations:

- Case Management Organization Standards
- Credential Verification Organization (CVO) Standards
- Health Call Center Standards
- Health Network Standards
- Health Plan Standards
- Health Utilization Management Standards
- Network Practitioner Credentialing Standards
- Workers' Compensation Network Standards
- Workers' Compensation Utilization Management Standards

- Several new accreditation programs also are under development

Since 1991, URAC has issued over 1,200 accreditation certificates to over 300 organizations doing business in all fifty states. URAC-accredited organizations provide managed care services to over 120 million Americans.

Because of URAC's broad-based standards and rigorous accreditation process, purchasers and consumers look to URAC's accreditation as an indication that a managed care organization has the necessary structures and processes to promote high quality care and preserve patient rights. In addition, regulators in over half of the states recognize the URAC's accreditation standards in the regulatory process.

URAC's quality mission also has diversified and expanded in recent years. For example, URAC is engaged in several research projects to assess and identify new approaches to improve performance measurement in a variety of health care settings. URAC is publishing cutting-edge books on the health care delivery system such as *The Survey of State Health Utilization Review Laws and Regulations*, *The PPO Guide*, *Case Management State Laws: A 50-State Survey of Health & Insurance Statutory Codes*, and *Models of Care: Case Studies in Healthcare Delivery Innovation*. URAC now offers over 40 days of educational conferences, workshops, and seminars annually on issues ranging from accreditation to best practices.

Who decides whether an organization is accredited?

Before accreditation is awarded, an organization participates in a thorough multi-step evaluation process. The basic elements of the process are a self-assessment completed by the organization itself and an on-site survey conducted by a team of physicians, health care managers, and other health professionals who actively practice in organizations similar to those surveyed. All surveyors are volunteers, serving without pay because they believe in promoting high quality ambulatory health care (Schuster et al., 1997).

The accrediting organization's Board of Directors - another volun-

peer group of health care professionals - renders the final accreditation decision based on the surveyors' findings and other information gathered during the survey process. Accreditation may be awarded for either, one or three years, depending on the level of compliance with the standards (WHO/EMRO, 1999; WHO/SEARO, 1998).

Why Accreditation?

There are several areas where the quality of health care is falling short, including underuse, overuse, misuse, and variation in use of health care services. Accreditation identifies these and forces the health care organization to address each of them. This process is usually carried out through the survey and the re-accreditation phases.

- **Underuse of Services:** The failure to provide a needed service can lead to additional complications, higher costs, and premature deaths. For example, a study of heart attack patients found that nearly 80 percent did not receive life-saving beta-blocker treatment, leading to as many as 18,000 unnecessary deaths each year. A survey of managed care plans by the National Committee for Quality Assurance (NCQA) found that 60 percent of diabetics age 31 and older had not received a recommended eye exam in the previous year. The same survey reported that 30 percent of women age 52 to 69 had not had a mammogram in the previous 2 years, and 30 percent of women between ages 21 and 64 had not had a Pap smear in the previous 3 years, despite the fact that early screening reduces mortality (MMC, 1997).
- **Overuse of Services:** Unnecessary services add costs and can lead to complications that undermine the health of patients. For example, half of all patients diagnosed with a common cold are incorrectly prescribed antibiotics. Overuse of antibiotics has been shown to lead to resistance and as much as \$7.5 billion a year in excess costs (Rakich, 1995). Another study found that 16 percent of hysterectomies performed in the United States were unnecessary (Narsavage, 1999).
- **Misuse of Services:** Errors in health care delivery lead to missed or

delayed diagnoses, higher costs, and unnecessary injuries and deaths. A study of New York State hospitals (Gonen and Presbyn, 1996) found 1 in 25 patients were injured by the care they received and deaths occurred in 13.6 percent of those cases. Negligence was blamed for 27.6 percent of the injuries and 51.3 percent of the deaths. Based on this study, researchers estimated that preventable errors in hospital care led to 180,000 deaths per year. Researchers estimate that as many as 30 percent of Pap smear test results were incorrectly classified as normal.

- **Variation of Services:** There are significant variations in the practice of medicine across the United States, among regions, and even within communities. For example, hospital discharge rates are 49 percent higher in the Northeast than they are in the West (Lieberman, 2000). A person with diabetes is one-and-a-half times as likely to get a needed eye exam in New England than in a Southern state.

The Accreditation Process

The accreditation process consists of a “desktop review” of the application and a site visit. Through this process, applicant organizations submit evidence of compliance with accreditation standards, which is then verified by an accreditation reviewer.

Once the desktop review is complete, the organization may be asked to submit additional information and/or revisions to the application. After receipt and review of the additional documentation, an onsite visit will be scheduled. Applicants should refer to the Interpretive Guide to prepare for the onsite verification. The processing time for an application, that is the time an application is received at the accreditation head quarters until the time the accreditation is granted, is approximately four to six months. The actual time frame will vary according to the type of accreditation applied for, the number of standards that are met versus not met upon desktop and onsite review, the number of applicant sites, and the number of applicants in the queue for accreditation, among other factors (NCQA, 2000; URAC 2000).

The survey process of accreditation varies with each of the agencies. AAAHC, NCQA, URAC, and JCAHO have differing ways of surveying the process for which a health care provider will receive accreditation.

AAAHC (2000) stresses that the “basic elements of the process are a self-assessment completed by the organization itself and an on-site survey conducted by a team of physicians, health care managers, and other health care professionals who actively practice in organizations similar to those AAAHC surveys. All surveyors are volunteers, serving without pay because they believe in promoting the high quality ambulatory health care.”

NCQA (2000) defines the process as “a rigorous one, consisting of both on- and off-site evaluations conducted teams of physicians and managed care experts. A national oversight committee of physicians analyzes the team’s findings and assigns an accreditation level based on the plan’s compliance with NCQA’s standards.”

URAC (2000) gives the definition of the process as “a desktop review of the application and a site visit. Through this process, applicant organizations submit evidence of compliance with accreditation standards, which is then verified by a URAC accreditation reviewer.”

JCAHO (2000) asserts that the accreditation process “is recognized worldwide as a symbol of quality that indicates an organization meets certain performance standards. To earn and maintain accreditation, an organization must undergo an on-site survey by a Joint Commission team at least every three years.

Each agency, tasked with the mission of improving health care, stress the importance of the review and process for accreditation. The people involved in the process are not strangers to the health care industry; they are health care professionals who know which factors would allow for the accreditation of an agency. It is essential that they are professionals involved in the process themselves and that they are able to see the items that a health care provider would need to change in order to provide the best care for patients. The steps for the survey vary for each agency

(MMC, 1997) but the main concept is the same: to ensure that the review is one that takes all factors into consideration by a group well versed in the concept of the best health care.

These accreditation agencies have methods of surveying the accreditation of agencies. It is through these methods that the hospitals and other health care agencies receive certification to show the consumers that they are serious about the factors that are taken into consideration with an accreditation survey. But what are these factors that determine the success of the survey? Accreditation agencies have their own standards by which they evaluate the level at which a health care provider operates. There are many different standards and AAAHC, NCAQ, URAC, and JCAHO have different methods for evaluating the health care provider. Below is a quick overview of the types of standards each agency has for the accreditation of health care agencies and providers.

AAAHC publishes the “Accreditation Handbook for Ambulatory Health Care”. In this handbook, there are descriptions of the standards for accreditation. The factors described in the handbook relate to: Quality of the Care and Quality Management and Improvement, Clinical Records, Pharmaceutical Services, Facilities, and Environment, Governance, Administration, and Professional Development.

NCAQ (2000) defines the standards by which a health care agency operates with the following categories: Access of Service, Qualified Providers, Staying Healthy, Getting Better, Living with Illness.

URAC (2000) standards are defined as: Accreditation Overview, Scope of Services, Personnel, Operations/Process, Quality Improvement, Delegation of Responsibilities, Confidentiality, Grievances, and Complaints.

JCAHO (2000) evaluates in the following items in the survey: Patient Rights and Organizational Ethics, Assessment of Patients, Care of Patients, Education, Continuum of Care, Improving Ongoing Performance, Management of Environment of Care, Management of Human Resources, Management of Information, Infection Control, Governance, Medical Staff, Nursing, Management.

Although each of the criteria by which an accreditation agency decides the quality of the health care provider varies in name of the item, the characteristics are the same. In the survey, it is imperative that the health care provider does its utmost to ensure that each of the standards is met and that there is a continual striving for improvement. In order to see the requirements and how they must be fulfilled, it is imperative that we do an in-depth evaluation of the criteria and see how it relates to the needs of each agency in fulfilling the code by which they check the standards of health care. It is by checking each of the items of the standards for each agency that we will be able to determine the best way that a health care agency will receive accreditation. The standards are basically similar but there is more of an emphasis with some agencies on particular items. It is by understanding what each agency stresses that a health care agency or provider will best ensure that they will receive accreditation.

For AAAHC, the “Rights of Patients” standard is the one by which all the rest of the standards revolve around. According to the AAAHC (2000) that standard is “the very essence of the accreditation process...to determine that the health care organization is positively addressing essential elements to ensure the rights of patients and to provide the highest level of care possible.” It is from this point that AAAHC makes its evaluation on the other criteria, Governance, Administration, Quality of Care, Quality Management and Improvement, Clinical Records, Professional Standards, and Facilities and the Environment. The surest way for a health care agency to pass these standards is to first ensure that the Rights of the Patient are clear and enforced.

For NCQA (2000), the standards listed above correspond to some very essential questions. The first question for Access and Service asks, “Do health plan members have access to the care and service they need? Are doctors in the health plan free to discuss the treatment options available? Do patients report problems getting needed care? How well does the health plan follow up on grievances?”

Here, the first question also goes to the right of patients. It is essen-

tial for accreditation that the patients not only receive the best service possible, but that certain rights are afforded to the patient. It is the patient's rights that are stressed.

The next question in the area of "Qualified Providers is: "Does the health plan assess each of the doctor's qualifications and what do health plan members say about their providers? Again, the opinion of the patient is stressed here. What is said about these agencies or plans?

For all three of the following questions, the emphasis here is on the quality of the health plan itself. It has less to do with the opinion and reaction of the patient and more with the level of service provided. For Staying Healthy, the question is, "Does the health plan help people maintain good health and avoid illness?" In "Getting Better", the question is "How well does the health plan care for people when they become sick?" And finally, in "Living with Illness": the question is "How well does the health plan care for people with chronic conditions?" There is less emphasis here on the patient's opinion and more on the quality of service.

These factors and the answer to the above question are essential to the evaluation of health care services. If a health care provider were interested in receiving accreditation with NCQA, it would have to verify that it meets the requirements listed and that there is some kind of striving towards the fulfillment of the standards.

For URAC (2000), the essential standards are somewhat unique, because they also identify the quality of not just HMOs but PPOs, case management organizations, worker's compensation, and managed care. For this reason, the standards listed are a little broader and address the health care accreditation as a whole.

The first standard is an Accreditation Overview. Here, the question asked is "What are the main areas covered by the accreditation standards?" This broad question puts patient rights into consideration, being one of the most significant items that an accreditation agency looks for. "URAC's critical mission is to promote the accountability of health care organizations, especially organizations that provide managed care services. Managed care quality is a critically important issue for patients."

Again, here the emphasis is on the comfort of the patient. These items also relate to the comfort of the patient. Confidentiality: What are the confidentiality requirements? Grievances and Complaints: How can patients, employers or provider register grievances or complaints with the organization?

Secondary is the quality at which the health care provider gives the service. And the next standards address the quality: Scope of Services: What is the mission statement of the organization? Personnel: What are the staffing requirements to provide the services? Operations/Process: What activities must an organization undertake to ensure high quality services? Quality Improvement: What is the organization's quality improvement program? Delegation of Responsibilities: What are the obligations to contract out services?

The factors shown for URAC are similar to those of AAAHC and NCQA. The standards are basically stressing the right of the patient and the services provided, as a secondary item. It is not that the quality is not important, it is just more significant that the patient have a good experience with the health care provider and this correlates directly with the quality of the service.

For JCAHO (2000), the factors listed are very much related to the ones listed above. The first is Patient Rights and Organizational Ethics. Again, here, the first item directly relates to the rights of the patient. Organizational Ethics relates to the ethical treatment of patients. The next items: Assessment of Patients and Care of Patients relate more to the quality of service provided to the patient. The next items: Education, Continuum of Care, Improving Ongoing Performance, Management of Environment of Care, Management of Human Resources, Management of Information, Infection Control, Governance, Medical Staff, Nursing, Management relate to the general quality of the service and the quality of the staff. This demonstrates once again the very similar priorities for each of the health care agencies. JCAHO also stresses another element, and that is of the management of health care provider.

By checking the standards of each agency and weighing the impor-

tance of each one, we are able to conclude that the patients' rights are of the utmost importance (Al-Assaf, 1994). The success of the survey is heavily reliant upon the rights of the patient. The surest way to not pass an accreditation survey is to give little importance to a patient's rights. The second most determining factor is the quality of the service, which directly relates to the patients' satisfaction (Al-Assaf, 1996).

The factors relating to standards for all the above accreditation agencies stress the significance of patients' rights. The next most determining factor, quality, is also significant (Al-Assaf, 1998). The overall factors that determine the success of an agency receiving accreditation are close attention to the two aforementioned standards.

The most significant lesson an agency can learn in passing accreditation is the importance of the consumer and the way in which they are perceived. In the information age, the level of standards that a health care provider dispenses in easily accessible (Berwick, 1989). Information is disseminated on the agency and the rating that the accreditation agency gives is very important to the health care provider or agency. Both NCQA and JCAHO provide easy methods for a consumer to access information on a health care provider or agency on the Internet.

NCQA (2000) has an online database listing "report cards" for health care providers. Assuming your health care provider has been assessed by NCQA, you can type in the name of your plan is able to access the level at which your provider provides the standards NCQA has established. Sentara Health Management, as an example, has an excellent rating under the "703" area code of providers. Consumers wishing to choose a health care provider for their region would look for the one with the highest rating. And, in this particular case, Sentara Health Management would be the leading health care provider.

JCAHO (2000) also has a searchable database on its site that allows consumers to view the accreditation level of the health care provider of choice. This searchable database allows an individual to search under the status of the health care provider. The highest level achieved for JCAHO in the level of accreditation is "Accredited with Commenda-

tion". A search of this database for health care providers in Washington DC yielded only one agency: The Psychiatric Institute of Washington, DC. You are able to access the description of this term and learn what it means to have the title: "Accredited with Commendation" The description given follows:

An accreditation decision awarded to a health care organization that has demonstrated more than satisfactory compliance with applicable Joint Commission standards in all performance areas on a complete accreditation survey

This description shows that the health care provider has given outstanding service to the patients and placed the rights of the patient foremost. It is a symbol to the public and the health care providers that their service is commendable and encourages the influx of new patients and talented staff.

In both of these cases, the health care provider, through the commendation of NCQA and JCAHO will attract the consumers and some of the most talented individuals in the health care industry. The lesson that an organization learns is that there is nothing more significant than the approval of their peers and the satisfaction of their customers.

When a health care provider passes accreditation, they are assured that they are providing the best service they can to their clients, and perhaps more significantly, they learn what their requirements mean and what they can do for their services (MMC, 1997).

On the other end of the scale, there are many negative repercussions for those health care providers or agencies that receive a negative rating and do not pass for accreditation (MMC, 1997). When someone has their life at stake, you can be certain that they will seek out the best medical attention. If a health care provider or agency does not have accreditation or conditional accreditation, it is certain to be at a very high risk for decreased amount of patients and a general loss of faith in their services (Pinker, 2000). Nothing could be more detrimental to a health care provider.

If, for example, a health care agency has a negative rating with one

of the accreditation agencies, they could be singled out as a last option for consumers. Because consumers have access to the databases both NCQA and JCAHO offer to consumers and because of all the literature that is available to all consumers, it is simply not good practice to not seek out accreditation.

A search on the JCAHO database, the Quality Check, for an agency in Maryland with conditional accreditation had three listings, the first of which was “Adventist Healthcare Rehabilitation Hospital”. A description of this conditional accreditation follows:

Fails to demonstrate satisfactory compliance with applicable Joint Commission standards in multiple performance areas; is persistently unable or unwilling to demonstrate satisfactory compliance with one or more Joint Commission standards; or has failed to comply with one or more specified accreditation policy requirements, but is believed to be capable of achieving satisfactory compliance within a stipulated time period.

This description is an almost entirely negative one. One can almost be assured that a consumer would lose faith in such an agency by just reading that description. Regardless of the reason why the health care provider was given such a low rating, and the reason is not given on the database, it just reflects badly upon the agency. One can assume that this agency probably did not meet the stringent requirements JCAHO gives for a patient’s rights. Through the watchful eye of accreditation agencies, the health care providers must be certain to pass or surpass the regulations given to them. Through the research and analysis of the statements and requirements, we have been able to conclude that the most important factor is that of patient’s rights and how that correlates to the quality of the service provided. Without careful attention to these standards and requirements, especially in the arena of a patient’s rights, the health care provider or agency will be in great danger. Consumers, in this new age, have access to a wealth of information—especially through the Internet and through other publications these agencies publish (Al-Assaf, 1998). With the increased number of consumers aware of ac-

creditation and standards, health care agencies that snubbing accreditation will soon find themselves snubbed by consumers.

Accreditation ... Is it worth it?

Accreditation is a key component of quality assessment because it provides an in-depth evaluation of health care organizations capacity to deliver acceptable quality of care. Accreditation signals that structural elements that deliver good care do exist and should be required in the health industry, in particular the ambulatory care industry. However, accreditation still does not guarantee the level of quality provided (Zasa, 1999).

Accreditation essentially involves external review, usually both on- and off-site, of a health plans performance along a number of specified dimensions. Based on the results of such a review, the accrediting body will either award or deny an accreditation status, usually at one of several distinct levels.

Hospitals and other healthcare facilities traditionally have sought the status gained through accreditation as validation that the care they delivered was of high quality (Leebove and Ersoz, 1989). When Congress passed the Medicare act in 1965, lawmakers included a provision specifically that hospitals accredited by what was then called the joint Commission on Accreditation of Hospitals were “deemed” to be in compliance with most federal conditions for participation in Medicare and Medicaid (JCAHO, 2000).

For almost four decades, accreditation has been the highest form of public recognition a health care organization could receive in recognition of its quality care (JCAHO, 1987). Accreditation initially began with hospitals, but today thanks to the Accreditation Association for Ambulatory Health Care (AAAHC), nearly all types of ambulatory health care providers can achieve this distinction. Accreditation offers many more quantitative as well as intangible benefits to an ambulatory surgery center than public recognition alone. Accreditation can actually enhance a center’s strategic management decision-making process. The

commitment of ambulatory health care professionals to improve the quality of care with recognized standards, and to share their experiences through education and consultation are policies that ambulatory accreditation organizations implement in their accreditation process (AAAHC 2000). Those who have achieved accreditation say it helps them:

- Find new ways to improve the care and services they offer
- Increase their efficiency and reduce costs
- Develop better risk management programs
- Lower liability insurance premiums
- Motivate staff and instill pride and loyalty
- Strengthen public relations and marketing efforts
- Recruit and retain qualified professional staff members
- Develop alliances with other provider groups such as hospitals

and managed care organizations. (Gonen, 1996)

But most importantly, it helps deliver their ultimate bottom line - high quality patient care. The National Committee on Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), as well as AAAHC's own standards, encourage sub-components of managed care organizations and provider networks to be accredited by appropriate accrediting entities.

The continuous nature of required care constantly challenges those managing ambulatory care. Quality assurance in ambulatory care has become increasingly complex, as systems of health care have become more diversified in the United States of America. Structures, processes, and outcomes have been used to define quality before moving to a specified focus. Today's organizational climate focuses on cost effectiveness (Omachonu, 1991).

Analysts of structural quality would examine a facility's policies such as administrative standards, personnel policies and procedures, staffing in terms of educational requirements and job descriptions, and financial management plans. Criteria for quality management related to process focus on how care is provided. A definition of quality using criteria related to outcomes explores the results obtained. Assessment

would include whether specified goals have been achieved and negative events avoided; whether the quality of life had been attained or maintained, and whether patients and their families expressed satisfaction with the care provided.

Perspectives of Health Care Leaders on Accreditation

The health care consumers are becoming increasingly sophisticated in their demand for information about their choice of health care plans. Many purchasers, including governments and employers, expect health plans to have the seal of approval of an independent accrediting body (JCAHO, 1999). Although accreditation originated as a voluntary process, it has become virtually essential for managed care plans that compete in a complex marketplace.

Consumers, large purchasers, clinicians, health planners, and policymakers must present the results of a quality measurement system in a format that can be understood easily, perhaps by developing a standard set of measures that covers the domains of interest to various constituencies, or different organizations that measure quality might work together to create greater uniformity across their systems.

The quality of health care provided varies among hospitals, cities, and states and countries. However, the same techniques exist to measure quality of care. Clinicians and health plans can use information on quality to determine where the quality of the care they provide needs improvement. If this information is made available regularly and in an interpretable form, through interpretability, uniformity and standardized information systems, consumers and large purchasers can also use it to make informed decisions when choosing among clinicians and plans, which will, in turn, give providers an added incentive to improve quality.

Policymakers can also use information about the quality of care to determine the impact of public and private changes in the health care marketplace. The private sector has been the driving force behind this transformation, but the public sector has been an active participant as well, as experienced in the reform of Medicaid managed systems (Ber-

wick, 1989). Regardless, the strategy will need to cover the aspects of quality that patients care about; collect data in a way that is manageable, reasonable, and affordable; and produce information in a format that is useful for those who are in a position to improve quality (Schuster, McGlynn, and Brook, 1997).

Advantages of Accreditation

Many ideas are rich with measures to ensure quality of care. By helping consumers and purchasers make informed choices about health care, information on quality can help consumers make informed choices. Most consumers know little about the technical proficiency of the physicians and other health care providers they choose (Longo and Bohr, 1991). Some ask friends for referrals. Some choose providers based on limited information in a health maintenance organization's brochure, such as age, gender, and medical school. Some choose providers based on convenience of location. When selecting a health plan, consumers may compare price and covered services, but they can find it difficult to learn how well plans provide care in general or for particular conditions. Quality monitoring can provide such information to help consumers decide where and from whom to obtain care (Longo and Bohr, 1991).

Information on quality can also help public and private group purchasers of care. Companies that provide health insurance for their employees must decide which health plans to make available. Similarly, state and federal governments must decide which health professionals can provide care to beneficiaries of government-funded health insurance. As concerns have increased about rising health care costs, many large purchasers have considered price of care as the primary factor in determining which health plans to offer. Yet, while it is tempting to believe that more efficient plans trim costs in health care while keeping essential and necessary services, research has not shown this to be true (Omachonu, 1991). Instead, studies reveal cost containment to be a blunt instrument that, by itself, results in the elimination of both necessary and unnecessary care (Juran, 1992). Quality assessment and monitoring

provide the tools we need to balance cost and quality.

What assists physicians and patients to make informed treatment and referral decisions is information. Information on quality is useful for physicians and patients when making specific treatment and referral decisions.

Clinicians and health plans can improve their care by using information concerning their own quality of care to improve the care they provide. Monitoring quality provides the opportunity not only to address inferior quality, but also to identify and learn from examples of superior quality. By determining the impact of new policies and systems, which is rapidly changing because of private and public market forces and policies, all involved can make better choices for quality care.

The health care system is changing so rapidly that most studies of how well it provides care are already out-of-date. A systematic approach for collecting and measuring information on quality would facilitate the production of information that is more timely and representative of current delivery systems.

Lastly, by providing input to the financial decision-making processes, cost-cutting efforts creates newer incentives for health plans to reduce the amount of care provided, which may actually improve the health of the population when useless or harmful care is eliminated. However, when necessary care is cut, health may decline (Berwick, 1989). Quality of care criteria can help guide decisions about which type of care should be maintained and which type might be safely eliminated. Better decisions should result in the delivery of a more effective package of services (Hart and Hart, 1989).

Disadvantages of Accreditation

Currently, the American health care industry continues to be unable to systematically measure and report on the quality of health care delivered to its patients. Problems arise from the lack of comprehensive information, primarily sprouting from an associated lack of information and accountability, especially when conducting state licensing and on-site quality review - processes and outcomes have become shrouded in a

veil of silence (MMC, 1997). With a continued lack of complaint investigation and meaningful enforcement by state and federal authorities problems related to a lack of information and accountability will continue to hinder development in quality care.

Lessons Learned

Contingent assumptions representing the range of perspectives on the accreditation system, is that accreditation necessitates control of demographic and other differences in enrolled populations and for factors outside of the control of the health care delivery system that influence the processes and outcomes of care. These elements can be moderated through risk-adjustment. By learning new treatments, the accreditation system needs to be able to adapt accordingly. Otherwise, it will become obsolete. Diversity ensures that quality measures can provide different types of quality care. Process, structural and outcome measurement systems supplant support to overall accreditation systems. Most importantly, if quality measurement systems are supposed to assess the full spectrum of quality in health plans, they need to develop more effective information and data collection systems, because this information will be collected from multiple sources, like medical records, laboratory reports, claims data, and patient surveys. Computer systems that collect and merge key pieces of clinical information will facilitate quality measurement and redress related issues of confidentiality and security of computer records. Furthermore, information needs to be presented in a manner that clarifies its relevance to the health care system and to consumers themselves, and information systems can aid information organization of this sort (Al-Assaf, 1998).

Most importantly in order to assure the full dissemination of information, full participation is necessary to ensure that appropriate comparisons are made (Deming, 1986). Without uniformity of this sort, it is difficult to compare quality that has been measured by different systems; because their specifications for data collection are different.

Recommendations

The accreditation system in all facets of the health industry must be population-based so that it takes into account everyone who could benefit from care whether or not they use services. Otherwise, the system will discourage enrollees with complex or expensive conditions from seeking care. The accreditation system should cover all aspects of a health care delivery system because quality of care may vary within an organization. These aspects include types of care, appropriateness, and settings. It should also cover conditions, especially complex medical conditions, which are usually more expensive and difficult to provide and account, and are of particular interest to certain communities or groups. If the quality of this care is not specifically measured, some plans may choose to skimp on such care while still obtaining good overall quality scores. Factors important in creating effective quality monitoring and effective assessment systems are that its population-based, holds a broad coverage, allows room for risk adjustment, adaptability and diverse measures, information systems, interpretability, uniformity and full participation. These factors necessitate the essential exchange of information and the relevance of converging focal points to respond to myriad of divergent voices in the field of health management and accreditation systems.

Conclusions

The movement to measure medical quality through accreditation and performance indicators is a fledgling one, driven largely by purchasers of health care. Although accreditation remains a voluntary process, most of the large managed-care companies now consider it essential in highly competitive markets (NCQA, 2000). Governments, which have a legal obligation to safeguard people who rely on publicly funded medical care, and many private foundations value the accrediting organization as an ally that can help pressure health plans, clinics and hospitals to ensure and improve the care they provide (JCAHO, 2000). Nonetheless, the science of quality measurement is in its infancy. The accrediting organizations have been thrust to the forefront because of the support it

enjoys among employers and because of the vacuum left, in part, by the reluctance of the American Medical Association (AMA) and other medical organizations to take the lead. Recently, the AMA decided to develop a quality-assessment program for physicians' offices, in large part because many doctors feel harassed by the repetitive surveys conducted by or on behalf of the health plans with which they contract (Gonen and Probyn, 1996).

The accrediting organizations have acknowledged that they must engage the medical profession more directly and are creating a physicians' advisory body. In the past year or so, people representing private purchasing coalitions, states, the elderly, and other consumers of care have joined the board of directors (JCAHO, 2000). At a time when increased government regulation of health care is in great disfavor, the accrediting organizations are thriving. However, this new organization suffers from all the pains attendant on rapid growth. It is uncertain whether its voluntary processes are capable of accommodating the conflicting interests of patients, payers, physicians, and hospitals.

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ملخص البحث

نظراً للتوجه الجديد في اعتماد الجهات الصحية من خلال المرضى ، فقد أصبح نجاح الخدمات الصحية المقدمة معتمداً بشكل كبير على اسلوب هذا الاعتماد الذي تسعى كافة جهات العناية الصحية على اختلاف تخصصاتها التي تشمل عيادات الجراحة ، ومراكز مجموعة التخصصات المتعددة ، والمستشفيات ومنظمات الصيانة الصحية ، ومراكز الولادة، والخدمات الصحية التابعة للكليات والجامعات وعيادات معالجة الآلام ، وكذلك العيادات الطبية الجامعية ، للحصول عليه . إذ لا تعفى أية جهة تعمل على تقديم العناية الصحية من الحصول عليه واعتماد تلك الهيئات لها . إلا أنه قد تظهر تساؤلات عديدة بخصوص ماهية مصطلح الاعتماد ؟ وما هي الجهات المسؤولة عن تقديمه ؟ وما هي المعايير الموجودة والتي يجب توفرها لاعتماد مركز تقديم العناية الصحية ؟ وما هي العوامل المرتبطة بذلك ؟ وكيف يمكن لمركز تقديم العناية الصحية أن يجتاز المتطلبات الصارمة لتلك الجهة ؟ وما هي الخطوات التي يجب اتباعها لانتهاء إجراءات الحصول على الاعتماد ؟ لذا ، فإن أفضل طريقة للإجابة على تلك التساؤلات هي اللجوء للمصدر ، أي الجهات المخولة لمنح الاعتماد . ويركز هذا البحث على أربع من أشهر تلك الجهات فكل واحدة منها تعريفها الخاص واتجاهاتها ومعاييرها المستخدمة للاعتماد ، في حين تعمل كل واحدة منها لتحقيق هدف رئيسي يتمثل في تحسين نوعية العناية الصحية المقدمة . كما يصف البحث البنية التنظيمية والطريقة المنهجية لمتابعة الحصول على الاعتماد ، وكذلك المزايا والتحديات التي تواجه جهات منح اعتماد العناية الصحية .