CAN ACCREDITATION WORK IN PUBLIC HEALTH?
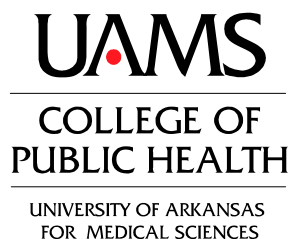
LESSONS FROM OTHER SERVICE INDUSTRIES

Working Paper Prepared for the Robert Wood Johnson Foundation

November 30, 2004

Glen P. Mays, Ph.D., M.P.H.
Department of Health Policy and Management
College of Public Health
University of Arkansas for Medical Sciences

UAMS

**COLLEGE OF
PUBLIC HEALTH**

UNIVERSITY OF ARKANSAS
FOR MEDICAL SCIENCES

EXECUTIVE SUMMARY

Accreditation programs have developed for a wide variety of health and social service organizations over the past several decades in response to rising pressures for improving the quality and value of services and strengthening the viability and competitive position of organizations that provide these services. Many of the pressures that motivated the development of existing accreditation programs currently face the field of public health. These circumstances suggest that if accreditation programs have been successful in strengthening the delivery systems for other health and social services, they may hold promise for the field of public health. This paper reviews the literature on the experiences and outcomes of existing accreditation programs in health and social service industries in order to derive implications about the potential benefits and costs of accreditation for public health agencies.

This review finds that existing accreditation programs have developed to achieve a variety of different goals and objectives, ranging from improving service quality and standardizing service offerings, to improving the competitiveness of the service industry and insulating the field from political influence. The governing structures and accreditation processes created for these programs initially reflected the interests of the program sponsors, but many programs have evolved over time to represent the interests of multiple stakeholders within the field of practice, including service providers, purchasers, consumers, and regulators. Relatively few accreditation programs rely on evidence-based performance standards that are tightly linked to desired service outcomes, but some programs have made recent progress in this direction. The degree of success experienced by accreditation programs in achieving widespread adoption and use of their programs hinges largely on the strength of the incentives faced by organizations within the industry to pursue and maintain accreditation.

Limited but encouraging evidence exists to suggest that accreditation programs produce positive effects on service quality, service outcomes, and the operations of service providers. Although the volume and strength of this evidence is modest, the available studies provide a reasonably consistent picture of positive program effects. Moreover, we found no clear evidence suggesting that accreditation programs have had severe unintended and adverse effects on service providers and their communities. However, the sizable costs incurred by organizations that undergo accreditation have the potential to create significant barriers to accreditation for many organizations that perhaps could benefit most from the process—including organizations serving disadvantaged and under-resourced communities.

This review of the experience with accreditation suggests several important conclusions and policy implications for the field of public health as it considers the potential value of accreditation:

1. Accreditation programs hold potential for promoting improvements in service delivery, operations, and outcomes in public health. Ultimately, however, the success of any program will depend critically on the specifics of its design and implementation and the environment in which it is introduced.

2. Accreditation programs entail significant costs that must be weighed against the potential benefits to determine feasibility and value. To generate the information necessary to support such an assessment, policy-makers may wish consider the use of an accreditation pilot study, demonstration program, or experiment similar to those used in other fields of practice.

3. The costs of accreditation programs need to be distributed and financed equitably to ensure they do not preclude participation by organizations that could benefit most. To prevent disparities and inequities in access to accreditation, policy-makers may need to consider financing strategies that subsidize the costs of accreditation and spread these costs equitably across the public health system as a whole.

4. Strong incentives for seeking and maintaining accreditation appear essential to the viability and success of accreditation programs. If used, such incentives should be phased in gradually over time to avoid adverse consequences associated with short-term shifts in resources.

5. Governance for any accreditation program should include representation from the full array of stakeholders engaged in the field of practice to ensure responsiveness, fairness, credibility, and a balanced perspective.

6. Accreditation programs should facilitate progress toward evidence-based practice and emphasize performance standards that have strong and consistent links to desired outcomes. Such programs should bring together the scientific and practice communities on an ongoing basis to develop, validate, update, and improve evidence-based standards of practice.

I. INTRODUCTION AND RATIONALE

Voluntary accreditation programs have emerged in a growing number of organizational fields within the U.S. health care system and other service industries during the past half-century. While these programs vary considerably in their specific objectives and rationale, all have developed in response to some measure of internal and external pressure to improve the quality and value of services produced by these industries and to expand the viability and competitiveness of the industries as a whole. In response, these programs have endeavored to provide purchasers, consumers, regulators, employees, or other stakeholders with assurance that services conform to commonly accepted standards. As such, accreditation programs function as an increasingly visible component of the mechanisms through which society assures accountability and value for its investments in health and social services.[1] Other components of accountability mechanisms include governmental licensure and regulation, payment methods and incentives, professional education and training, professional guideline development and dissemination, performance measurement and reporting, continuous quality improvement efforts, and litigation.

Established accreditation programs now cover many types of health, social, and public service organizations in the U.S, including medical care providers, health insurers, educational institutions and programs, child and family service agencies, and law enforcement and public safety agencies (Table 1). Public health agencies remain one of the few organizational components of the U.S. health and social service system that have yet to develop an accreditation program tailored to their specific scope of activities. While some of the individual services delivered by selected public health agencies are covered under existing accreditation programs—such as those for home and community-based nursing services, ambulatory medical care services, and laboratory services—a comprehensive, national accreditation program for state and local public health agencies does not exist. Evidence about persistent gaps and wide variation in the adequacy of the nation's public health infrastructure across states and communities raises the question of whether an accreditation program for public health agencies could help to close these gaps and improve the capacity of the nation's public health system to protect and promote health.[2]

This paper reviews the literature on the experiences and outcomes of existing accreditation programs in health and social service industries in order to derive implications about the potential benefits and costs of accreditation for public health agencies. The paper pursues answers to four overarching questions:

(1) What are the goals and objectives of existing accreditation programs and how consistent are they with the goals and objectives of the public health system?

(2) What design features and implementation processes have been used to develop existing accreditation programs, and how transferable are they to public health settings?

(3) What outcomes have been achieved by existing accreditation programs, and what were the intended and unintended effects on service delivery organizations and on the communities they serve?

(4) What program characteristics and environmental conditions appear associated with the success or failure of accreditation programs, and what do these associations imply about the likelihood of a successful program for public health agencies?

TABLE 1

ACCREDITATION PROGRAMS EXAMINED IN THIS ANALYSIS

Accreditation Program	Organizations Accredited
American Association of Poison Control Centers Accreditation Program	Regional poison control centers
American Medical Association Accreditation Program (AMAP)	Physician practices (discontinued in 2000)
American Red Cross Performance Standards	Local chapters of American Red Cross
Association for the Accreditation of Human Research Protections Programs (AAHRPP).	Institutional Review Boards (IRBs)
Commission on Accreditation for Law Enforcement Agencies (CALEA)	State and local law enforcement agencies
Commission on Accreditation for Rehabilitation Facilities (CARF)	Physical rehabilitation centers, vocational rehab centers, employment training centers, child and family centers, aging and continuing care centers
Commission on Fire Accreditation International	Local fire departments
Community Health Accreditation Program (CHAP)	Home health agencies, hospice programs, community nursing agencies, specialty home care services, public health agencies
Council for Health Services Accreditation of Southern Africa (USAID sponsored)	Public hospitals in South Africa

TABLE 1 (CONT.)

ACCREDITATION PROGRAMS EXAMINED IN THIS ANALYSIS

<u>Program</u>	<u>Organizations Accredited</u>
Council on Accreditation of Services for Families and Children (COA)	Social service agencies, behavioral health care agencies, financial management and debt counseling agencies
Council on Higher Education Accreditation	Post-secondary educational institutions
EAP Accreditation Program	Employee assistance programs
Emergency Management Accreditation Program (EMAP)	State, territorial, and local emergency management agencies
HRSA Accreditation Program	Federally Qualified Health Centers (FQHCs)
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	Hospitals, health care networks, home care & hospice, nursing homes, behavioral health, ambulatory care, assisted living, clinical labs, disease management, office-based surgery
National Association of Insurance Commissioners (NAIC) Accreditation Program	State insurance agencies
National Association for the Education of Young Children (NAEYC) accreditation of early child care programs	Child care centers
National Committee for Quality Assurance (NCQA)	Commercial, Medicaid, and Medicare HMOs; PPOs; disease management vendors
Opioid Treatment Accreditation Program (SAMHSA-supported)	Opioid addiction treatment programs
UK Further and Higher Education Act Accreditation Program	Education and training programs for adults in the United Kingdom
Utilization Review Accreditation Commission (URAC)	Utilization review organizations, disease management vendors, health plans
Zambia National Hospital Accreditation Program (USAID sponsored)	Public and voluntary hospitals in Zambia

II. INFORMATION SOURCES AND METHODS

This analysis focuses on accreditation programs developed in the health care, education, social service, and public service industries. We limit the study to these industries because they provide services that are similar in scope and nature to those provided by public health agencies. Moreover, the institutional and economic structures found within these industries are similar to those found within the public health system, including the significant involvement of governmental agencies in service delivery, the presence of both state and local agencies with overlapping responsibilities, and the important roles of state and federal government funding sources. To maximize the ability to generalize findings, we give primary emphasis to accreditation programs developed for U.S. service delivery organizations. However, we include literature on programs developed in other countries where these studies employ particularly strong research designs that offer evidence not available from studies of domestic programs.

To identify published literature on accreditation programs in these industries, we conducted searches in a series of bibliographic databases. We searched the MedLine database to identify publications in the health sciences, management, and policy literature; the ERIC database to identify publications in the education and social services literature; EBSCO Business Source Elite to identify publications in the business literature; EconLit to identify publications in the economics literature; and GPO Access to identify relevant federal government documents. In each database we performed both keyword searches and subject heading searches with the term "accreditation," and also performed keyword searches with the names of specific accreditation programs and accreditation bodies such as JCAHO, CARF, NCQA, and NAEYC. Additionally, to identify grey literature on accreditation programs we performed web searches on the term "accreditation" and on specific accreditation program names and accreditation bodies using the Google internet search engine.

We also fielded brief telephone interviews with key respondents who work in or study the accreditation field to identify other sources of information about program experiences and outcomes. Interviews were conducted with individuals from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), National Committee for Quality Assurance (NCQA), the U.S. Substance Abuse and Mental Health Service Administration (SAMHSA), the U.S. Health Resources and Services Administration (HRSA), the Council on Accreditation (COA), and Research Triangle Institute (RTI).

After eliminating editorials and opinion pieces, we identified 94 documents containing relevant descriptive and empirical information about the design, operation or impact of accreditation programs. These documents were reviewed for content and relevant information was abstracted into a database for analysis and synthesis.

III. **MAJOR FINDINGS**

The evidence base concerning the effectiveness and impact of accreditation programs remains relatively limited despite the proliferation of these programs in service industries during the latter half of the 20th Century. Many industries and organizations have adopted accreditation programs, like other institutional innovations, without waiting for the availability of clear evidence that these programs work as intended. Studies from the innovation diffusion literature suggest that this pattern of adoption is particularly likely to emerge in environments where: (1) organizations face strong internal and/or external pressures to respond to a problem or issue; (2) organizations face few promising alternatives for responding to the problem; (3) the innovations to be adopted are flexible and amenable to improvement over time as organizations learn what works; and (4) adoption is reversible if results do not live up to expectations.[3-5] These circumstances are evident in many of the service industries that have developed accreditation programs in recent decades.

A. Purpose and Goals of Accreditation Programs

Accreditation programs have developed in the health and social service industries to achieve a variety of goals and objectives. An individual program's purpose and goals derive from the interests of the institutions that created and sponsored the program. Programs created by service providers are likely to give priority to goals of mutual interest to the industry, such as facilitating the visibility and legitimacy of services provided by the industry, distinguishing the industry from competing service providers, and limiting the entry of new and/or inferior organizations into the industry.[6] By contrast, programs created by purchasers or consumers of services may pursue a somewhat different set of goals, such as assuring the quality and value of services provided by the industry, ensuring that providers can deliver a standard set of services, and facilitating the compatibility and interoperability of services provided by different organizations. In many cases, however, accreditation programs fall under the governance of multiple stakeholders including providers, purchasers, and consumers. In these circumstances, program goals may reflect objectives that are shared among all stakeholders, or they may reflect a mix of objectives preferred by each stakeholder, with the specific mix determined by the amount of power and control enjoyed by each stakeholder.

Goals of Existing Accreditation Programs. Table 2 lists the types of goals and objectives pursued by the accreditation programs included in this study. Several programs were founded by provider organizations and initially emphasized objectives of interest to the industry, but later adopted a broader set of objectives as other stakeholders became more engaged in the program. For example, the Community Health Accreditation Program (CHAP) was founded jointly by the National League of Nursing and the American Public Health Association (APHA) and initially focused on increasing awareness of the legitimacy and value of home nursing services.[7,8] However, CHAP was later spun off as an independent agency and granted the authority to "deem" accredited home health and hospice providers as eligible to participate in the Medicare program (deemed status)— developments that made the federal government a more important stakeholder in the program as a purchaser of health services. Consequently, the goal of ensuring quality and patient safety in home care services soon became an overriding goal of the program. A

similar transition is evident in the development of the Commission on Accreditation of Rehabilitation Facilities (CARF), which was initially created by two professional associations to promote the recognition and legitimacy of their members' services but rapidly evolved to a focus on promoting quality and consumer protection after receiving deemed status for Medicare.[9]

TABLE 2

GOALS AND OBJECTIVES PURSUED BY ACCREDITATION PROGRAMS FOR HEALTH AND SOCIAL SERVICE ORGANIZATIONS

<u>**Provider-focused Objectives**</u>
- Promote professionalization, visibility and legitimacy of the service industry
- Increase demand for services produced by the industry
- Distinguish services provided by the industry from those of competing industries
- Limit entry of new and/or inferior organizations into the industry
- Reduce the need for direct governmental regulation of the service industry
- Encourage increased public and private contributions of resources necessary to achieve and maintain accreditation
- Facilitate recruitment and retention of skilled staff
- Provide a buffer against political influence

<u>**Purchaser, Consumer, and Shared Objectives**</u>
- Assure and improve the overall quality and safety of services provided
- Assure and improve the overall cost-efficiency and value of services provided
- Reduce variation in the type and nature of services provided and/or ensure that providers can deliver a standard set of services
- Encourage adherence to best practices in service delivery and operation
- Facilitate coordination and interoperability of services provided by different organizations
- Ensure institutional and financial stability of service organizations

---

By contrast, the Council on Accreditation of Services for Families and Children accreditation was founded through a grant from the federal Department of Heath, Education and Welfare (HEW, now Health and Human Services) with the primary goal of improving the quality of child welfare services, a key priority of the federal government as purchaser and regulator of these services.[10] Similarly, the Utilization Review Accreditation Commission (URAC) was founded by a coalition of large employers with the primary goal of standardizing the practices and services offered by medical management companies so that services would be implemented uniformly across employee populations and provider organizations.[11] Moreover, the educational accrediting bodies endorsed by the federal Council on Higher Education Accreditation were selected in part to facilitate easy transfer of credit between educational institutions—a form of interoperability that is of keen interest to consumers and purchasers of post-secondary education.[12]

Many accreditation programs have developed organizational and governance structures that represent the interests and objectives of multiple stakeholders in order to achieve greater legitimacy and appeal to a broader range of organizations. For example, URAC eventually added health care providers, insurers, and consumer organizations to its board of directors in order to include a broader and more balanced set of interests regarding medical management practices in the health insurance industry. Some observers credited this development with eliminating the perceived need for stronger state and federal government regulation of medical management practices.[13] Similarly, the National Committee for Quality Assurance (NCQA) added provider and consumer organizations to its governance committee to complement the employer and insurer interests that provided the initial impetus for its accreditation program.[14]

Consistency with Public Health Goals. Many of the goals and objectives pursued by existing accreditation programs appear consistent with the goals of interest to public health agencies. Most of the objectives listed in Table 2, for example, could apply with minor modification to state and local public health agencies. These agencies have a clear interest in encouraging greater public and private investments in public health services and in increasing the visibility and legitimacy of their services with stakeholders such as employers, insurers, health care providers and community organizations. These agencies also face a pressing need for strategies to improve the overall quality and efficiency of services and enhance service coordination and interoperability across agencies. This consistency of goals provides some preliminary support for the argument that an accreditation program could provide a viable means through which public health agencies pursue objectives and interests within their field of practice.

B. Design Features and Implementation Processes of Accreditation Programs

Governance Structures. Most accreditation programs are governed by a board of directors that includes representation from major stakeholders within the service industry. Accreditation boards establish major policy directions for their programs, including decisions about the types of organizations accredited, the assessment processes employed, and the financing strategies pursued. For some programs, majority membership on the board of directors is held by representatives of the organizations who are accredited by the program. For example, early childhood education professionals hold a majority of seats on the accreditation board for the National Association for the Education of Young Children (NAEYC).[15] Similarly, the accreditation board for the Commission on Accreditation for Law Enforcement Agencies (CALEA) is populated primarily by representatives of law enforcement agencies.[16] Other accreditation boards are controlled by other stakeholders within the industry, including purchasers or consumers of services. For example, the JCAHO accreditation board for hospitals and other health care facilities has always been dominated by members of physician associations including the American Medical Association, the American College of Physicians, and the American College of Surgeons. American Hospital Association representatives have only a minority voice on the JCAHO board. Many other accreditation boards are comprised of representatives from a broad

range of industry stakeholders. URAC's board, for example, includes membership from health insurers, physician associations, hospital systems, employers, benefits consultants, and state insurance regulators. Similarly, NCQA's accreditation board includes membership from employers, unions, health plans, and health care consumers.

Accreditation boards comprised primarily of representatives from accredited organizations may find it easier to identify and act on issues of concern to the industry and reach agreement on major policy issues. However, in some cases these accreditation programs risk being perceived as offering self-interested or less-than-comprehensive assessments of their industry, thereby reducing the credibility and effectiveness of the program as viewed by outside stakeholders. For this reason, accreditation boards comprised of broad cross-sections of industry stakeholders may enjoy greater external support from purchasers, consumers, and other stakeholders.

Design of the Accreditation Process. Most of the accreditation programs examined in this analysis rely on assessment processes that involve both a self-study and a site visit to determine compliance with established standards of practice. Organizations begin the process by filing an application containing description information about the organizational structure, governance, history, and scope of services offered by the applicant. Next, applicants conduct a self-assessment that provides an internal appraisal of the organization's degree of compliance with core standards of practice as established by the accreditation program. As a third step, representatives from the accreditation program conduct a site visit to the applicant organization to verify results from the self-assessment and assess other elements of organizational performance. Assessment strategies used during the site visit may include direct observation of operations, review of written policies and procedures, review of administrative and clinical records, and interviews with employees and clients. After these steps are completed, accreditation programs typically share preliminary results with the applicant and provide them with an opportunity to clarify findings and offer supplemental evidence regarding compliance with standards.

As a final step, members of the site visit committee score results from the assessments using established criteria and determine the accreditation status of the applicant. Most accreditation programs offer multiple levels of accreditation based on assessment scores that may range from the highest level of "accredited with commendation" to lower levels such as standard accreditation, accredited with recommendations for improvement, provisional accreditation, and non-accredited. Organizations receiving recommendations for improvement may be required to submit an improvement plan and report measures of progress periodically during the accreditation cycle. Organizations receiving provisional accreditation may be required to take remedial actions and participate in a partial or full re-assessment during the accreditation cycle. Additionally, some accreditation programs include a status of pre-accreditation for newly developed organizations that have not been in operation long enough to meet all standards required for standard accreditation. This status is often used in programs that require evidence of longitudinal improvements in performance over time as part of their accreditation standards.

Most programs use an accreditation cycle of three to five years with re-accreditation required after each cycle. The COA program for child welfare agencies, for example, requires re-accreditation every four years, whereas the NAIC program for state insurance agencies and

the EMAP program for emergency management agencies require re-accreditation every five years. The accreditation program used by the American Red Cross for its local charters relied on a five year cycle until 2004, when it moved to an annual cycle in order to encourage ongoing quality improvement activities among its charters. This short accreditation cycle is an exception to the general trend of multi-year cycles found in most programs.

Some programs allow the accreditation cycle to vary with the level of accreditation status achieved, such that organizations accredited at lower status levels are required to return for re-accreditation at shorter intervals. This design provides an incentive for organizations to aspire to higher accreditation status levels and thereby reduce the frequency and cost of re-accreditation. Health plans seeking NCQA accreditation, for example, may achieve an accreditation cycle ranging from one to three years depending on their assessment scores. Many programs also require accredited organizations to submit annual reviews and performance reports during the accreditation cycle.

Development of Accreditation Standards and Measures. Most accreditation programs focus their accreditation processes around a collection of standards, performance measures, and assessment criteria developed internally by the program. Programs typically develop these standards using an expert panel process involving professionals and scholars with experience in the relevant field of practice. In most cases, accreditation standards reflect structural and process-based measures of organizational performance derived from the consensus judgments of expert panelists. Despite growing attention to evidence-based practice in the health and social service fields, relatively few accreditation programs rely on performance standards that have a documented empirical relationship to desired service outcomes. Moreover, relatively few programs incorporate objective measures of service outcomes directly into the assessment process. Collection of reliable outcome measures and empirically-validated process measures has proven too costly and administratively complex for many accreditation programs to undertake to date.

A few notable exceptions exist, however. NCQA collects an array of clinical quality and patient-assessed quality measures annually for health plans that participate in its accreditation program and/or its Health Plan Employer Data and Information Set (HEDIS) reporting system—including measures related to the control of major chronic diseases and the delivery of clinical preventive services. Since 1999 NCQA has used performance on selected HEDIS measures as a significant portion (27 percent) of the overall accreditation score for health plans. NCQA maintains an audit process to verify HEDIS measures reported by health plans.

Several other accreditation programs have taken steps to incorporate objective, validated measures of service quality and outcomes into their accreditation standards process. Since 1997 JCAHO has required accredited hospitals to undertake quality improvement activities using validated quality measures from its Oryx measurement set.[17] Hospitals may choose from any of the more than 200 measures included in this set. Additionally, the CHAP accreditation program for home health agencies recently launched an initiative that allows accredited agencies to voluntarily submit clinical quality and outcome measures to a data repository and receive customized performance benchmarking reports. Agencies receive credit on their accreditation assessments for submitting these data and using the resulting benchmark reports for quality improvement efforts.

Most accreditation programs rely on a relatively large collection of performance standards and measures that reflect multiple domains of organizational performance. Common domains of performance include the scope of services offered, service quality, consumer protection and safety, financial performance and stability, administrative processes, staffing and training, and customer service. The Emergency Management Accreditation Program, for example, uses 54 standards that fall within 14 broad functional areas that include these generic domains plus several specialized domains such as risk assessment, hazard mitigation, and communications and warning. By comparison, the American Red Cross accreditation program includes 47 standards in 6 generic domains. Fourteen of these standards are considered core requirements that must be performed in order to retain a Red Cross charter, whereas the remaining 30 standards, considered critical performance areas, are used to differentiate chapters based on performance levels.

Scoring Criteria. Most accreditation programs use a single set of standards and scoring criteria for assessing all organizations that undergo accreditation review. While this approach offers a measure of administrative simplicity, it potentially raises questions about whether organizations operating in under-resourced environments and serving disadvantaged communities should be judged by the same set of standards and criteria as is used for more advantaged organizations. If an organization's resources and capacities are determined in part by environmental conditions that are beyond the control of the organization, then arguably these conditions should be taken into account when assessing the organization's compliance with standards of practice.[18] Only one of the accreditation programs reviewed in this study employed a method to "risk-adjust" performance standards and criteria for environmental conditions likely to affect organizational performance. The American Red Cross accreditation program developed a method of sorting its charters into peer groups based on four types of local area characteristics that were found to be significantly associated with charter performance levels in previous analyses—population size, population density, average household income, and ethnic composition. Performance measures are then compared only within peer groups to derive relative performance scores. Only the 30 standards considered to be critical performance areas are risk adjusted in this way; the remaining 14 standards are considered core requirements for all Red Cross charters and are not adjusted for area characteristics.

Incentives for Accreditation. The success experienced by a voluntary accreditation program in achieving widespread adoption and use hinges largely on the strength of the incentives faced by organizations within the industry to pursue accreditation. Organizations must weigh these incentives against the requisite costs and risks to determine whether a sufficient business case exists for pursuing accreditation. Among the accreditation programs reviewed in this analysis, those having the strongest incentives for accreditation achieved the highest rates of adoption within their service industries. Accreditation incentives may take a variety of forms, but the most powerful and visible incentives are those that provide accredited organizations with expanded funding and business opportunities (Table 3).

In the health care industry, one of the most powerful incentives for accreditation has been eligibility for participation in Medicare and other federal health care programs. The JCAHO accreditation program for hospitals has enjoyed "deemed status" for Medicare since the 1960s, meaning that accredited hospitals are automatically eligible for participation in

Medicare and are not required to undergo a separate health and safety inspection. This status has served as a powerful incentive for hospitals to achieve and maintain JCAHO accreditation. Subsequently several other accreditation programs have achieved Medicare deemed status for selected types of health care organizations, including the CHAP program for home health agencies and hospice programs, the CARF program for rehabilitation facilities, and NCQA for Medicare managed care plans. These same accreditation programs also have obtained deemed status with many state Medicaid programs. As a consequence, these programs have become some of the most widely adopted accreditation programs in the U.S.

TABLE 3

**INCENTIVES FOR ACCREDITATION
IN SELECTED ACCREDITATION PROGRAMS**

Program	**Strength and Nature of Incentives**
American Association of Poison Control Centers	Weak: Credibility with policy-makers
American Medical Association Accreditation Program (AMAP)	Weak: Health plans, hospitals, and physician organizations can use AMAP in place of an independent credentialing process.
American Red Cross Performance Standards and Re-Chartering Process	Strong: Core requirements are required to maintain charter status. Poor performance scores can result in remediation, take-over of services by national office, or revocation of charter status.
Commission on Accreditation for Law Enforcement Agencies (CALEA)	Moderate: Accredited agencies experience decreased liability costs, increased support from policy makers, improved recruitment and retention of staff.
Commission on Accreditation for Rehabilitation Facilities	Strong: Accredited centers receive deemed status under Medicare and Medicaid for rehabilitation services. Centers also receive preference for many state contracts and grant funds.
Commission on Fire Accreditation International	Moderate: Homeowners obtain lower insurance premiums by 3-4%
Community Health Accreditation Program (CHAP)	Strong: CHAP accredited agencies receive deemed status for Medicare for home health (since 1992) and hospice (since 1999). Accredited agencies also receive benchmarking data and consultation on quality improvement activities.
Council on Accreditation of Services for Families and Children	Moderate: Some states and localities give preference to accredited agencies in distributing contracts and funding for child and family services.
Council for Health Services Accreditation of Southern Africa	Moderate: USAID funding gives preference to accredited hospitals

TABLE 3 (CONT.)

**INCENTIVES FOR ACCREDITATION
IN SELECTED ACCREDITATION PROGRAMS**

<u>Program</u>	<u>Strength and Nature of Incentives</u>
Council on Accreditation program for social, behavioral, and financial services	Weak: Some purchasers give preference to accredited programs
Council on Higher Education Accreditation	Strong: Accreditation status determines eligibility for federal and state grants and loans and for transfer of credits between institutions. Accreditation status also used in recruiting prospective students and faculty.
EAP Accreditation Program	Weak: Some employers give preference to accredited programs
Emergency Management Accreditation Program	Weak: Support/encouragement from funding agencies including FEMA, DOJ, DOT, and individual states.
HRSA Accreditation Program	Moderate: Centers that are accredited or seeking accreditation do not undergo HRSA OPR review. HRSA pays accreditation fees and is considering differential payment levels for centers.
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	Strong: Accredited institutions are given deemed status for meeting health and safety standards for Medicare and Medicaid
NAIC Accreditation Program	Weak: Credibility with policy-makers
National Association for the Education of Young Children (NAEYC) accreditation of early child care programs	Strong: Federal Child Care and Development Block Grant funds targeted to accredited centers in several states. Some communities target Community Development Block Grant funds targeted to accredited centers in some communities. GSA and Armed Forces give preference to accredited centers.
National Committee on Quality Assurance (NCQA)	Moderate: Some purchasers use accreditation status in making purchasing decisions. Medicare allows NCQA accreditation as deemed status for health plan participation. Some state Medicaid programs also provide deemed status.
OTP Accreditation (SAMHSA)	Strong: Required to receive CSAT funding. Some states give deemed status to accredited programs for state funding.
UK Further and Higher Education Act Accreditation Program	Strong: Public funding tied to accreditation
Utilization Review Accreditation Commission (URAC)	Moderate: Some purchasers use accreditation status in making purchasing decisions.
Zambia National Hospital Accreditation Program	Moderate: USAID funding gives preference to accredited hospitals

The incentives for accreditation in the educational services sector also appear quite strong. The U.S. Department of Education requires that post-secondary education institutions receive accreditation through one of the programs recognized by the Council on Higher Education Accreditation in order become eligible for receiving many federal educational grants and student loans. As a consequence, educational institutions must seek accreditation in order to be successful in recruiting and retaining talented students. Similarly, eligibility for many research grants awarded by federal agencies such as the National Institutes of Health, National Science Foundation, and Centers for Disease Control and Prevention is limited to academic institutions accredited through one of the Council-recognized programs. In several states, federal block grant funding for early childhood education is restricted to child care centers accredited through the NAEYC program. Other states offer higher reimbursement rates to accredited child care centers.[19] Several federal agencies also give preference to accredited child care centers when purchasing these services.

For other accreditation programs, the incentives for accreditation depend heavily the extent to which purchasers value accreditation and choose to contract preferentially with accredited organizations. For health plan accreditation programs like NCQA and URAC, employer demand for health plans with these credentials is highly variable, with large employers valuing this accreditation more highly than smaller employers. Consequently, health plans face a mix of incentives for pursuing accreditation that depend upon the types of employers present in a given market. Some health plans have begun to allow their accreditation status to lapse because of insufficient demand from employers to maintain this status and rising costs of accreditation. The COA accreditation programs for employee assistance programs and behavioral health care providers confront a similar mix of incentives that are contingent on employer demand for accredited services.

At least one accreditation program was discontinued in recent years due primarily to a lack of sufficiently strong incentives for accreditation. The American Medical Association launched the AMAP program for accreditation of physician practices in 1996 under the expectation that hospitals and health plans would see value in this form of accreditation and purchase information about accredited physicians from the program as part of their professional credentialing processes.[20] After piloting the program with physicians in 10 states, spending more than $12 million and starting nearly 4000 physicians in the program, the AMA discontinued the program in early 2000 due to lack of sufficient demand from purchasers.[21] Program administrators concluded that the program could not be successful without a strong business case for physician accreditation generated by hospital and health plan demand.

Accreditation Funding Sources: Most of the accreditation programs in health and social service industries rely on fees paid by applicant organizations as their primary source of operating revenue. Fees are generally assessed based on the size and complexity of the applicant organization or organizational unit. Many programs supplement this income with revenue from sales of publications and instruction manuals as well as fees for conferences, training sessions, and specialized consultative services.[22] Several accreditation programs secured external grant support from program sponsors in federal government agencies and/or professional associations to cover initial development and start-up costs associated with creation of the programs. In some cases, programs used part of their start-up funds to

subsidize the costs of accreditation for their initial applicants, thereby creating a financial incentive for organizations to become early adopters of accreditation. For example, the AMA's AMAP accreditation program for physician practices held the accreditation fees to $50 per physician in order to induce significant numbers of physicians to enter the program. This strategy was successful in boosting physician participation despite the fact that hospital and insurer demand for the program remained low.

C. Outcomes and Impact of Accreditation Programs

Accreditation Applicants and Outcomes. One frequently raised concern about accreditation programs is that stringent performance standards and criteria will prevent many organizations from obtaining accreditation. The available evidence on accreditation programs for health and social service organizations suggest that programs vary widely in the extent to which organizations seek and successfully obtain accreditation status. However, we find little evidence to suggest that large numbers of eligible organizations are shut out of the accreditation programs launched to date.

Two program characteristics appear to explain at least some of the observed variation in accreditation applicants and outcomes across different accreditation programs: the age of the accreditation program and the incentives available for obtaining accreditation. Older programs have enjoyed longer periods of time to build awareness and support for accreditation among key internal and external stakeholders and to correct any deficiencies in accreditation processes. Additionally, programs with stronger incentives for accreditation enjoy clear advantages in recruiting eligible organizations to the accreditation process and retaining them for re-accreditation. Programs with both of these characteristics may enjoy high rates of applications and high rates of successful accreditation determinations. For example, over 80 percent of U.S. hospitals sought accreditation through the JCAHO program during the most recent cycle, and more than 99 percent of these hospitals received a determination of "accreditation with improvement recommendations" or better.[23] The application rate for NCQA's HMO accreditation program is somewhat lower than the JCAHO rate, presumably due to the somewhat weaker incentives for accreditation. Approximately half of all HMOs sought accreditation through NCQA in the most recent accreditation cycle, and of these only 7 percent failed to achieve at least a provisional accreditation score.[24]

Several newly established accreditation programs achieved considerably lower rates of successful accreditation determinations than the rates observed in established programs operated by JCAHO and NCQA. In the Emergency Management Accreditation Program, for example, 12 states have pursued accreditation since program inception in 2002 but only 4 states have achieved full accreditation and another 2 states have achieved provisional accreditation. During the four year operation of the AMA's AMAP program for physician practices, approximately 73 percent of the practices that applied for accreditation were granted this status. Similarly, during the initial demonstration of the accreditation program for opioid treatment programs, only about 85 percent of the programs achieved accreditation.[25] Two USAID-sponsored randomized experiments of hospital accreditation

programs in Africa have found even lower rates of accreditation. In Zambia only 2 of 12 hospitals achieved full accreditation after 2 years and in South Africa only 1 of 10 hospitals achieved accreditation.[26,27] Both of these studies, however, focused on hospitals in developing countries where very few organizational resources exist to support accreditation processes.

One possible explanation for the relatively high rates of accreditation determinations produced by established programs such as JCAHO and NCQA is that the accreditation standards and criteria used these programs assure only relatively minimal levels of quality and service in the organizations they review. This interpretation, which has been raised by several health care researchers, suggests that accreditation programs need to be combined with other, more powerful instruments such as performance measurement and reporting systems, pay-for-performance approaches, and quality improvement activities in order to have significant effects on organizational performance and quality of care.[28,29] However, another possible explanation for high rates of accreditation determinations is organizational self-selection into the accreditation program. For older and more established accreditation programs such as JCAHO and NCQA, eligible organizations have had ample time to learn whether they have the organizational capacity and resources necessary to achieve and maintain accreditation. Organizations that have little chance of meeting accreditation standards may simply decline to apply for accreditation. As a result, the pool of organizations that seek to acquire and maintain accreditation status becomes highly skewed toward those organizations most likely to meet accreditation standards.

Some evidence suggests that targeted support and training programs may be effective in helping organizations achieve accreditation. A recent study of the NAEYC accreditation program for child care centers found that an intensive support program for centers seeking accreditation doubled the odds that centers would receive accreditation. However, centers receiving only limited support were no more likely to achieve accreditation than centers pursuing accreditation independently.

Costs of Accreditation. Another common concern about accreditation programs is their potential to create financial burdens for the organizations subject to accreditation. The costs incurred by organizations seeking accreditation include not only the application and survey fees charged by the accrediting program but also the costs incurred for training and preparation prior to the accreditation site visit. Application and survey fees typically vary by the size and complexity of the organization. The average survey fees for hospitals in the JCAHO program currently total $23,000, for example, while the average fees for health plans in the NCQA program range from $40,000 to $100,000 not including HEDIS data collection.[14,30] Cost studies performed on these programs indicate that survey fees represent only about 10 percent of the total costs incurred by organizations seeking accreditation, with the remaining 90 percent of costs related to site preparation and staff training prior to the accreditation site visit.[31,32] A more recent cost study of the Opioid Treatment Program Accreditation Program found similar cost estimates, suggesting that the total cost of this program was nearly three times the final cost estimate published in the Federal Register.

Together, these findings suggest that organizations seeking accreditation should plan for significant expenditures above and beyond the required application and survey fees. Findings suggest that most of these costs are incurred in the final two months prior to the

accreditation site visit. These findings also raise concerns that the total costs of accreditation may pose significant barriers to accreditation for some organizations, particularly those serving disadvantaged populations and under-resourced communities. Recent research has revealed that cost is the primary reason why rural hospitals are much less likely than their urban counterparts to pursue JCAHO accreditation.[33] By limiting access to accreditation for organizations that may benefit most from it, the high costs of accreditation may reduce significantly the potential impact of an accreditation program.

In some cases, accreditation program administrators and policy-makers have taken steps to reduce the barriers presented by accreditation costs. The U.S. Health Resources and Services Administration (HRSA), for example, instituted a policy of paying the JCAHO accreditation fees for any HRSA-supported health center that seeks accreditation through the Health Center Accreditation Program.[34]

Impact of Accreditation on Service Quality and Outcomes. The available evidence concerning the impact of accreditation programs in health and social services industries remains relatively limited despite the growth of these programs in recent decades. Few well-controlled experimental studies of these programs have been undertaken to date, and observational studies of these programs are vulnerable to important sources of bias. In observational, non-experimental settings, differences in service quality between accredited and non-accredited organizations may be attributable to two possible effects: (1) a selection effect whereby higher-quality organizations self-select into the accreditation program while lower-quality organizations refrain from accreditation; and (2) a program effect whereby organizations that undergo accreditation improve their service quality in order to achieve program standards while organizations that do not pursue accreditation fail to improve. Distinguishing between these two effects is necessary to understand fully the impact of accreditation but is very difficult to do in the absence of an experimental study.

The available evidence concerning the impact of accreditation on service quality and outcomes derives from both observational and experimental studies. Findings from 6 of 9 observational studies and 2 of 2 experimental studies provide evidence that accreditation programs have positive effects on the service quality, operations, and outcomes of organizations undergoing accreditation. Taken as a whole, these findings provide moderate support for the beneficial effects of accreditation (Table 4).

Evidence concerning the impact of JCAHO and CARF accreditation programs is somewhat mixed but suggestive of possible program effects. Several observational studies of the JCAHO hospital accreditation program and the CARF rehabilitation facility program conducted over the past decade have failed to find a significant association between accreditation scores and measures of clinical quality, mortality, and patient satisfaction.[23,28,29,35-36] A more recent study, however, found that hospitals not participating in the JCAHO accreditation process achieved significantly lower clinical quality measures for myocardial infarction care and significantly higher mortality rates than their counterparts that did participate in accreditation. A second recent study of opioid treatment programs found that programs with JCAHO accreditation were significantly more likely to deliver appropriate doses of methadone than non-accredited programs.[37] The observational design of these two studies, however, precludes a definitive determination of whether the observed

differences in quality and outcomes are attributable to selection effects, program effects, or some combination of the two phenomena.

Evidence from several observational studies of the NCQA health plan accreditation program is also suggestive of positive program impact. A longitudinal, observational study of health plans during the 1990s finds some evidence that service quality differs between accredited and unaccredited health plans.[38] Accredited plans were found to have significantly higher clinical quality measures than non-accredited plans even after controlling for other observed differences between plans, but no differences were found between accredited and non-accredited plans in patient-reported measures of quality and satisfaction. Several other observational studies have documented significant improvements in HEDIS measures of clinical quality over time among NCQA-accredited health plans. While these findings are supportive of positive program impact, it remains possible that at least some of the observed differences in quality measures are attributable to selection effects rather than to the effects of the accreditation program.

Similarly, an observational study of the NAEYC accreditation program for child care centers finds additional support for the effectiveness of accreditation but again cannot rule out the possibility of selection effects. Centers that achieved accreditation exhibited higher initial classroom quality measures and larger improvements in quality over time than centers that sought but did not achieve accreditation and centers that did not seek accreditation. The study also finds that centers receiving intensive support for accreditation preparation achieved larger improvements in quality during the accreditation process than centers without this support.

Several other observational studies provide additional support for the hypothesis that accreditation programs contribute to improved quality of services. A qualitative study of social and behavioral services programs accredited by the Council on Accreditation found that accredited programs performed better than non-accredited programs in areas of risk management practices, performance evaluation, and corrective action practices.[39] No differences were found in the other seven performance domains studied. Similarly, a longitudinal, observational study of a hospital accreditation program implemented in Zambia found that hospital compliance with established standards of service improved significantly among hospitals exposed to the accreditation program and remained unchanged for the unexposed hospitals.

Findings from two recent experimental studies of accreditation programs provide additional evidence of the effectiveness of accreditation in improving service delivery and operations in selected settings. First, the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored a randomized controlled trial of a new accreditation program for opioid treatment centers in order to obtain reliable, unbiased estimates of accreditation effectiveness that could inform the development and national roll-out of the program. Estimates from the trial, which was conducted during 1999-2001, indicated that the accreditation program led to significant increases in the availability of core treatment services including 24-hour emergency workers, individual counseling services, and use of appropriate methadone maintenance dosages. SAMHSA used findings from the study to make improvements to the accreditation program prior to a national roll-out. A national evaluation study of the program is now underway.

17

TABLE 4

SELECTED FINDINGS ON ACCREDITATION PROGRAM IMPACT

Program	Impact	Source
Accreditation programs for health professions schools	IOM review concluded that little evidence exists to suggest that accreditation status impacts quality of health professions education or quality of care delivered by professionals.	IOM 2003
American Red Cross Performance Standards and Re-Chartering Process	Previous rechartering process resulted in reduction of number of chartered units from 2605 in 1993 to 965 in 2003, primarily through mergers/consolidation.	American Red Cross 2004
Commission on Accreditation for Rehabilitation Facilities	One study found no significant differences in the organization or delivery of cognitive rehabilitation therapy for survivors of brain injury in CARF-accredited and non-accredited facilities.	CARF 2004; Mazmanian et al. 1993
Council for Health Services Accreditation of Southern Africa	Intervention hospitals improved average compliance scores from 48 percent to 78 percent while control hospitals remained at 43 percent. Significant improvements were noted in 20 of 21 performance indicators for intervention hospitals and no indicators for control hospitals. Among the independent quality measures examined, only nurse perceptions of quality were found to be significantly better in intervention hospitals than controls. Performance was correlated with good management support and information sharing among hospitals	Salmon et al. 2003
Council on Accreditation of Services for Families and Children	A study by HHS OIG in 1994 found no conclusive evidence about the impact of accreditation on agency operations and quality. Opinions about impact of accreditation varied: some felt that accreditation led to improvements in service, others felt no impact.	HHS 1994
Council on Accreditation program for social, behavioral, and financial services	Based on a matched comparison of accredited and nonaccredited programs, accredited programs performed better in areas of risk management practices, performance evaluation, and corrective action practices. No differences were found in internal quality monitoring, stakeholder participation, case record review, outcomes measurement, consumer satisfaction, personnel satisfaction, and other service-specific processes.	Pietrass 2004
HRSA Accreditation Program	Evaluation is now being conducted.	Taylor 2004

TABLE 4 (CONT.)

SELECTED FINDINGS ON ACCREDITATION PROGRAM IMPACT

Program	Impact	Source
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	Accreditation status and scores were not correlated with measures of patient satisfaction nor with outcome measures of quality. One study did find that hospitals not surveyed by JCAHO had lower quality scores for MI care and higher mortality rates than surveyed hospitals.	Griffith et al. 2002; Jesse and Schranz 1990; Chen et al. 2003; Barker et al. 2002; Hadley and McGurrin 1988
JCAHO (continued)	JCAHO's 1993 standards for hospital smoking bans were associated with near-universal hospital adoption of standards and significantly higher quit rates among hospital employees. JCAHO's 2002-03 standards on patient safety practices were cited as the primary drivers of hospital adoption of medication error prevention and adverse event prevention practices	Longo DR et al. 1988-2001; Devers et al. 2004
NAIC Accreditation Program	Failed to detect a major insurer insolvency in 5 states in 1999, leading GAO to cite the program for ineffectiveness	GAO 2001[40]
National Association for the Education of Young Children (NAEYC) accreditation of early child care programs	Centers achieving accreditation exhibit higher initial classroom quality and larger improvements in quality over time than those centers that seek but do not achieve accreditation, and than those centers that do not seek accreditation. Accredited centers had lower teaching staff turnover than centers that sought but did not achieve accreditation. Centers that receive intensive support achieve accreditation at twice the rate as centers that sought accreditation independently. Centers receiving intensive support were more likely to improve quality during accreditation process than centers receiving limited/no support.	Whitebrook, Sakai, Howes 1997
National Committee for Quality Assurance (NCQA)	Accredited plans have higher clinical HEDIS scores on average than non-accredited plans, but no difference in patient-reported measures of health plan quality and satisfaction. Plans obtaining accreditation experienced larger enrollment growth than non-accredited plans during the 1994-95 period, but this effect dissipated by 1996. Plans denied accreditation or who discontinue seeking accreditation do not appear to lose enrollment.	Beaulieu and Epstein 2002
Opioid Treatment Program Accreditation (JCAHO, pre-SAMHSA)	Patients in accredited units were 10 percentage points more likely to receive doses at or above recommended levels.	D'Aunno and Pollack 2002

TABLE 4 (CONT.)

SELECTED FINDINGS ON ACCREDITATION PROGRAM IMPACT

Program	Impact	Source
Opioid Treatment Program Accreditation (SAMHSA)	Staff turnover declined in accredited sites and increased in control sites; Accredited sites employed more 24-hour emergency workers; Accredited sites were more likely to increase level of staff training; Size of caseloads did not change; Individual counseling availability increased and group counseling decreased in accredited sites; average maintenance dose increased slightly in accredited sites; no significant difference or change in QA procedures	Wechsburg and Kasten 2004
UK Further and Higher Education Act Accreditation Program	Student participation and completion rates increased, but programs tailored to underserved populations decreased (working class adults, women). Apparent funding incentives to target students most likely to achieve successful outcome	Coats 1999
Zambia National Hospital Accreditation Program	Compliance with standards improved significantly in hospitals after the accreditation program was launched, from 35% of standards met at baseline to 48% met after 2 years. However, no differences were noted between hospitals that completed the full accreditation process and those that completed only the initial educational survey. Among independent quality measures, only the availability of essential lab tests was higher among exposed hospitals than unexposed hospitals. However, hygenic conditions and mortality two days after admission were better among hospitals that achieved higher compliance scores than hospitals with lower scores.	Tavrow et al. 2004; Bukonda et al. 2000

A second experimental study was recently funded by the U.S. Agency for International Development (USAID) to obtain reliable, unbiased estimates of the impact of a hospital accreditation program to be introduced in South African hospitals based on the JCAHO model. Estimates from this longitudinal study indicated that accreditation increased hospital compliance with established standards of service from an average of 48 percent to 78 percent in hospitals randomized to the accreditation intervention as compared to no change in the control hospitals. Like the SAMHSA study, findings from the USAID study were used to make changes to the design and operation of the accreditation program prior to national implementation. Both of the experimental studies provide strong evidence that the accreditation programs had positive effects on the quality of services delivered by organizations undergoing accreditation. Unlike the findings from observational studies, the randomized designs employed in these two studies assure that the observed program effects

do not result from preferential self-selection of organizations into the accreditation programs.

Impact of Accreditation on Service Delivery Organizations. A final concern about accreditation programs is their potential to adversely effect the operations of organizations subject to accreditation and precipitate organizational closures or consolidation. Interestingly, an explicit goal of the accreditation and re-chartering program launched by the American Red Cross in 1993 was to facilitate mergers among small and poorly performing local chapters as a quality improvement strategy. Available data suggest that this effort was highly successful, as the number of charters declined from 2605 in 1993 to 965 in 2003.[41] None of the other accreditation programs examined in this review were designed specifically to promote consolidation among organizations, and we found no evidence that these programs triggered such an outcome.

Several studies, however, suggest that accreditation programs have had positive effects on the operations of organizations undergoing accreditation. For example, staff turnover declined in the opioid treatment centers that pursued accreditation in the SAMHSA experimental study, while turnover increased in the control group centers. A similar finding of diminished staff turnover emerged from the study of the NAEYC accreditation program for child care centers. Yet another study found that health plans with NCQA accreditation experienced larger increases in membership than non-accredited plans during the early years of the accreditation program (1994-95), although these differences disappeared in later years.

Finally, several descriptive studies have highlighted the effectiveness of accreditation programs in encouraging the adoption of beneficial innovations in practice. For example, one year after JCAHO implemented a new accreditation standard requiring smoke-fee workplaces for hospital staff in December 1993, more than 96 percent of U.S. hospitals complied with the new standard and more than 41 percent had enacted workplace policies that were even stricter than the standard.[42,43] As a result of those changes in practice, hospital workers achieved significantly higher rates of quitting smoking than other workers in the same communities—a difference that began with the JCAHO smoking standards and continued for at least 5 years.[44,45] A more recent study found that new JCAHO standards for patient safety practices that were implemented in 2002 and 2003 have been the primary driver behind the rapid adoption of practices to reduce medical errors and adverse events in US hospitals across the country.[46] These findings suggest that accreditation programs can serve as effective vehicles for promoting beneficial changes in practice across entire service industries.

IV. IMPLICATIONS FOR PUBLIC HEALTH AGENCIES

Accreditation programs have developed for a wide variety of health and social service organizations over the past several decades in response to rising pressures for improving the quality and value of services and strengthening the viability and competitive position of organizations that provide these services. Many of the pressures that motivated the development of existing accreditation programs currently exist in some form in the field of public health. These pressures include heightened public concern about persistent gaps and

wide variation in the availability and quality of essential public health services, limited public and private investments in public health services, and difficulties demonstrating accountability and value for these investments to external stakeholders. These circumstances suggest that if accreditation programs have been successful in strengthening the delivery systems for other health and social services, they may hold promise for the field of public health.

A review of the evidence concerning the experiences and outcomes of accreditation programs in health and social services industries suggests several important conclusions and policy implications for the field of public health as it considers the potential value of accreditation:

1. **Accreditation programs hold potential for promoting improvements in service delivery, operations, and outcomes.** We found limited but encouraging evidence that accreditation programs produce positive effects on service quality, service outcomes, and the operations of service providers. Although the volume and strength of this evidence is limited, the available studies provide a reasonably consistent picture of positive program effects. Moreover, we found no evidence suggesting that accreditation programs have had severe unintended or adverse effects on service providers and their communities. Taken together, this evidence suggests that accreditation should be viewed as a promising strategy for strengthening the field of practice in public health.

2. **Accreditation programs entail significant costs that must be weighed against the potential benefits to determine feasibility and value.** Available evidence suggests that application and survey fees are only a small part of the costs incurred by service providers undergoing accreditation. The vast majority of costs are incurred in preparing for accreditation surveys and site visits and providing relevant staff training. To make informed decisions about the value of accreditation in public health, policy-makers need to assess the total costs of accreditation and weigh them against the expected benefits to the field. To generate the information necessary to support such an assessment, policy-makers should consider the use of an accreditation pilot study, demonstration program, or experiment similar to those conducted by SAMHSA as part of the development of the OTP Accreditation Program and by USAID as part of the development of hospital accreditation programs in South Africa. Such studies can also provide valuable information about how best to design and implement an accreditation program for specific organizational settings.

3. **The costs of accreditation programs need to be distributed and financed equitably to ensure they do not preclude participation by organizations that could benefit most.** The sizable costs incurred by organizations that undergo accreditation have the potential to create significant barriers to accreditation for many organizations that perhaps could benefit most from the process—including organizations serving disadvantaged and under-resourced communities. To prevent disparities and inequities in access to accreditation, policy-makers may need to consider financing strategies that subsidize the costs of accreditation and that spread these costs equitably across the public health system as a whole.

4. ***Strong incentives for seeking and maintaining accreditation appear essential to the viability and success of accreditation programs.*** Accreditation programs appear to function successfully as voluntary initiatives as long as strong and visible incentives exist for organizations to undergo and maintain accreditation. Accreditation exists as a form of public good that potentially generates benefits for the entire field as long as a critical mass of organizations participates. To ensure high levels of participation and discourage free-riding, meaningful incentives should be targeted to those that obtain accreditation. Policy-makers should explore incentives similar to those used in other fields of service, including targeted funding opportunities for accredited organizations and differential payment levels that reward accreditation. If introduced in the public health system, these types of incentives should be phased in gradually over time to avoid adverse consequences associated with short-term shifts in resources. Non-financial incentives should also be considered, including professional recognition, access to performance information and benchmarking databases, and specialized networking and professional development opportunities.

5. ***Governance for any accreditation program should include representation from the full array of stakeholders engaged in the field of practice to ensure responsiveness, fairness, credibility, and a balanced perspective.*** A broad and balanced governing board helps accreditation programs maintain respect and recognition from both internal and external stakeholders and remain responsive to changes in the field of practice. Important stakeholders for a public health accreditation program would likely include local, state, and federal public health agencies, consumer and community-based organizations, funding and regulatory agencies, and representatives from relevant areas of health care delivery and financing.

6. ***Accreditation programs should facilitate progress toward evidence-based practice and emphasize performance standards that have strong and consistent links to desired service outcomes.*** The field of public health has historically lacked a strong evidence base to inform the organization, financing, and delivery of public health services. To begin the path toward evidence-based practice, an accreditation program in public health should systematically review and incorporate what research is available about optimal public health performance while at the same time identifying areas where additional research is needed to elucidate evidence-based performance standards. Existing resources may include the *Guide to Community Preventive Services*, the *Guide to Clinical Preventive Services*, *Healthy People 2010*, and the *National Public Health Performance Standards Program*. Policy-makers should engage the scientific and research community in partnership with the public health practice community in an ongoing effort to develop, validate, update, and improve an accreditation program based on evidence-based standards of practice.

Ultimately, the success of any accreditation program will depend critically on the specifics of its design and implementation and the environment in which it is introduced. While accreditation may hold some potential for the field of public health, it is not a panacea and by itself is unlikely to yield meaningful and sustained improvements in practice. For this

reason, accreditation should be considered only in the context of an integrated system of tools and approaches for generating improvements in public health practice—including approaches to performance measurement, quality improvement, workforce education and training, financing, leadership development, and community engagement.

REFERENCES

1. Tuohy CH. Agency, contract and governance: shifting shapes of accountability in the health care arena. Journal of Health Politics Policy and Law. 2003;28(2-3):195-215.

2. Mays GP, Halverson PK, Baker EL, Stevens R, Vann JJ. Availability and perceived effectiveness of public health activities in the nation's most populous communities. American Journal of Public Health. 2004;94(6):1019-26.

3. Rogers EM. Diffusion of Innovations, 4th Edition. New York: Free Press; 1995.

4. Walston SL, Kimberly JR, Burns LR. Institutional and economic influences on the adoption and extensiveness of managerial innovation in hospitals: The case of reengineering. Medical Care Research and Review 2001;58(2):194-233.

5. Cain M, Mittman R. Diffusion of Innovation in Health Care. Oakland, CA: California HealthCare Foundation; 2002.

6. Conover CJ, Zeitler EP. Professional accreditation and licensure. Health Facilities Regulation Working Paper No. P-6. Durham, NC: Duke University Center for Health Policy, Law, and Management; 2004.

7. Mitchell MK. The Community Health Accreditation Program. Its strategic meaning to the home care industry. Caring. 1988;7(10):20-2, 24.

8. Community Health Accreditation Program. Overview of CHAP. http://www.chapinc.org/introduction.htm. [Accessed 11/05/04]

9. MacDonell C. The many benefits of facility accreditation. Journal of Long Term Care Administration. 1997;24(4):12-3.

10. Office of the Inspector General, U.S. Department of Health and Human Services. Accreditation of Public Child Welfare Agencies. Washington, DC: USDHHS; 1994. OEI-04-94-0010

11. Viswanathan HN, Salmon JW. Accrediting organizations and quality improvement. American Journal of Managed Care. 2000;6(10):1117-30.

12. U.S. Department of Education. Accreditation in the United States. Washington, DC: USDOED; 2003.

13. Wise D. UR accreditation raises questions among employers. Business and Health. 1993; 11(1):38-41.

14. Pawlson LG, O'Kane ME. Professionalism, regulation, and the market: impact on accountability for quality of care. Health Affairs 2002;21(3):200-207.

15. Whitebook M, Sakai L, Howes C. NAEYC accreditation as a strategy for improving child care quality. Washington, DC: National Center for the Early Childhood Workforce; 1997.

16. Cordner G. Relationship of accreditation to community policing. Washington, DC: National Institute of Justice; 2002.

17. Rudman W, Hewitt C. ORYX: opportunity gained or lost? Journal of the American Health Information Management Association. 1999;70(6):48-52.

18. Mays GP, Halveson PK. Performance measurement in public health. In Principles of Public Health Care Practice, Second Edition, edited by D.F. Scutchfield and W. Keck. New York: Delmar Publishers, 2002.

19. Gormley WT, Lucas JK. Money, accreditation, and child care center quality. New York: Foundation for Child Development; 2000.

20. Kmetik K. Physician performance measurement and improvement: The American Medical Accreditation Program (AMAP). Clinical Practice Applications 1998; 3(4).

21. Prager L. Physician accreditation program being re-evaluated. American Medical News Dec 13, 1999.

22. Public Health Foundation. Accreditation: a study of issues and characteristics applicable to public health. Washington, DC: Public Health Foundation; 1998.

23. Chen J, Rathore SS, Radford MJ, Krumholz HM. JCAHO accreditation and quality of care for acute myocardial infarction. Health Affairs. 2003;22(2):243-54.

24. National Committee for Quality Assurance. Quality Compass 2004. Washington, DC: NCQA; 2004.

25. Wechsberg WM, Kasten JJ. Quality of care, accreditation outcomes, and changes in opioid treatment after pursuing accreditation. Presented at the American Association for the Treatment of Opioid Dependence 20th Anniversary Annual Conference. Research Triangle Park: Research Triangle Institute, 2004.

26. Bukonda N, Abdallah H, Tembo J, Jay K. Setting up a national hospital accreditation program: the Zambian experience. Operations Research Results 1(8). Bethesda, MD: Quality Assurance Project; 2000.

27. Salmon JW, Heavens J, Lombard C, and Tavrow P. The impact of accreditation on quality of hospital care: KwaZulu Province, Republic of South Africa. Operations Research Insights 2(17). Bethesda, MD: Quality Assurance Project; 2003.

28. Griffith JR, Knutzen SR, Alexander JA. Structural vs. outcome measures in hospitals: a comparison of the Joint Commission and Medicare Outcomes Scores in hospitals. Quality Management in Health Care 2002 10(2):29-38.

29. Barker KN. Medication errors observed in 36 health care facilities. Archives of Internal Medicine 2002 162(16):1897-1903.

30. Cross MA. Money pit: is accreditation always worth the cost? Managed Care 2003; July.

31. Mihalik GJ, Scherer MR, Schreter R.K. The high price of quality: a cost analysis of NCQA accreditation. Journal of Health Care Finance, 2003;29(3):38-47

32. Rockwell DA, Pelletier LR, and Donnelly W. The cost of accreditation: one hospital's experience. Hospital and Community Psychiatry 1993;44(2):151-5.

33. Brasure M, Stensland J, Wellever A. Quality oversight: why are rural hospitals less likely to be JCAHO accredited? Journal of Rural Health. 2000 Fall;16(4):324-36.

34. Taylor AM. Overview of the Division of Clinical Quality. Presented at the Public Housing Primary Care Fall Meeting. Bethesda, MD: U.S. Health Resources and Services Administration; 2004.

35. Hadley TR, McGurrin MC. Accreditation, certification, and the quality of care in state hospitals. Hospital and Community Psychiatry. 1988;39(7):739-42.

36. Mazmanian PE, Kreutzer JS, Devany CW, Martin KO. A survey of accredited and other rehabilitation facilities: education, training and cognitive rehabilitation in brain-injury programmes. Brain Injury. 1993;7(4):319-31.

37. D'Aunno T, Pollack HA. Changes in methadone treatment practices: results from a national panel study 1988-2000. JAMA 2002;288:850-856.

38. Dean Beaulieu N, Epstein AM. National Committee on Quality Assurance health-plan accreditation: predictors, correlates of performance, and market impact. Medical Care. 2002;40(4):325-37.

39. Pietrass J. The impact of accreditation on organizational functioning and performance. New York: Council on Accreditation; 2004.

40. U.S. Government Accountability Office. Insurance Regulation: the NAIC Accreditation Program Can Be Improved. Washington, DC: GAO; 2001.

41. American Red Cross. Performance driven chapter evaluation system: report and recommendations of the chapter performance standards workgroup. February, 2004.

42. Longo DR et al. Implementing smoking bans in US hospitals: results of a national survey. Tobacco Control 1988;7:47-55.

43. Longo DR et al. Smoking bans in US hospitals: results of a national survey. JAMA 1995;274:488-491.

44. Longo DR et al. Hospital smoking bans and employee smoking behavior: results of a national survey. JAMA 1996;275: 1252-1257.

45. Longo DR et al. A prospective investigation of the impact of smoking bans on tobacco cessation and relapse. Tobacco Control 2001;10:267-272.

46. Devers KJ, Pham HH, Liu G. What is driving hospitals' patient-safety efforts? Health Affairs 2004;23(2):103-15.