

The Commission on Accreditation of Rehabilitation Facilities (CARF- International) – A historical analysis

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ABSTRACT

This Major Paper provides a historical analysis of the formation and development of CARF-International, a prominent private accreditation body in the social and human services sector. Accreditation is a system of evaluation, whereby organizations or programs are reviewed based on an established set of standards, in order to become approved, or 'accredited'. Private accreditation, and specifically CARF accreditation, has become mandated and recognized by numerous government agencies across North America, and often acts as a requirement for human/social service agencies to access government funding. However the history and evolution of accreditation, and specifically accrediting institutions in the social/human services sector is not well researched, therefore the purpose of this paper is exploratory.

The paper begins with an overview of the literature on accreditation, accrediting institutions, as well as select literature on policy trends in public management, the welfare state, and transnational private regulation. The research is accomplished through a historical case study methodology that draws loosely on research questions utilized in previous research on accrediting institutions. I have identified three broad phases in the evolution of CARF-International: the foundational years (late 1960s to late 80s); building the market (1990s); and growth and expansion (2000s onwards).

Through the analysis I have identified seven key themes that relate the literature review to the evolution of CARF-International: the initial purpose of developing standards and accreditation; accreditation as private regulation; governance structure; CARF as a forum for debate; competition between accrediting institutions; the international 'turn'; and program evaluation. One point of interest is the position of CARF in a governance network (or 'infrastructure'/'assemblage') that crosses traditional boundaries of public-private or local-global. A second point is the changing nature of CARF as an institution—specifically in terms of industry involvement in the governance of CARF—as well as the influence of increasing competition and pressure for growth on the practices of CARF as an institution. A third point for further inquiry questions the impact of accreditation on service providers, and service delivery systems.

Overall this Major Paper offers an in-depth look at CARF as an accrediting institution as a means to expose and explore trends in accreditation and the broader field of social and human services.

FOREWORD

This Major Paper links directly to my area of concentration—Systems Intervention in Social Policy and Planning—as it applies the systems-thinking notion of ‘boundary critique’ [inherent in my first component, *A Systems Approach to Research & Intervention*], to expand the frame of what is generally included in research and intervention related to my other two core components: *Social Exclusion & Youth Homelessness*, as well as *Social Policy & Planning*. This major paper helped me to accomplish several of my learning objectives. First, under the component of *A Systems Approach to Research & Intervention*, it will allowed me to explore the systems of governance that relate to social policy and planning in Canada and the United States. Second, this major paper research allowed me to achieve the objective to develop a reading knowledge of theoretical literature relevant to the fields of social policy and planning. Third, in completing this Major Paper I gained basic skills in analyzing the institutional and regulatory framework under which social policy and planning occur, in order to contribute original research to the field. In this way, this research has allowed me to accomplish key components of my Plan of Study.

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INTRODUCTION

This paper is exploratory in nature. The purpose is to contribute information and new perspective to an important component of the social services sector – private (or ‘third-party’) accreditation. Accreditation is “a system and a process for reviewing institutions and programs against certain quality standards, in order to approve or credential them as well as to improve them (Worthen, Sanders, and Fitzpatrick in Brommel, 2006, p. 1). Private accreditation implies that the development of standards, as well as the evaluation process, are administered by a private institution, generally formed and governed by actors and/or organizations related to the field of practice. The standards relate to various aspects of organizational management and administration, program evaluation, health and safety, amongst other things.

This research has been instigated and informed by my experience as a front-line worker in the service system for street-involved youth in Vancouver, British Columbia (BC). In 1999, BC’s Provincial Ministry of Children & Family Development (MCFD) approved a policy to require third-party accreditation for all contracted service providers with funding over \$500,000 (MCFD, n.d.). As the MCFD is considered the most significant funder of street-youth services in Vancouver (Guenther, 2011, p. 71), this policy has had a substantial impact on shaping the front-line and administrative practices of service providers, as well as the broader landscape of service providers, by framing the conditions for funding eligibility. However in the context of British Columbia, there is very limited research on accreditation, and it is limited to the impact of accreditation on front-line workers (see: Janz, 2004; Bates, 2005; Janz, 2014).

More broadly, while literature exists on the history and theory of accreditation in specific fields, such as education and medicine, research on social service accreditation is limited and tends to be narrow in focus. Yet beyond the context of street-youth services in Vancouver, as argued by Hazard, Pacinella & Pietrass (2002) in Brommel (2006, p. 4): “accreditation remains the most powerful, consistent, nongovernmental influence on social service organizations”. Currently, the literature on accreditation in social services is focused primarily on the accreditation process from the perspective of frontline workers (see: Janz, 2004; Bates, 2005; Lirette, 2012; Janz, 2014), or on the impact of accreditation on organizations or programs (see: Slatten, Guidry, and Austin, 2011; Carman & Fredericks, 2013). Yet there is very limited research on where standards and accreditation come from—i.e. the institutions that develop and administer accreditation.

As described by Bartley (2007, p. 309), “institutions arise out of political, cultural, or professional projects led by strategically positioned and social skilled ‘institutional entrepreneurs’”. While much of the discourse surrounding accreditation, and accrediting institutions is technical and apolitical (i.e. ‘best practices’), measurement and evaluation through accreditation is inherently political, occurs within a context of power relations, and is influenced by dominant values and ideologies (see Agocs & Brunet-Jailly, 2010, p. 161). Thus standards setting institutions are the milieu for the “detailed implementation of both policy and politics” (Salter, 1998, p. 163).

As further elaborated within the literature review and methodology of this Major Paper, an in-depth look at the emergence and evolution of an accreditation institution offers a forum to explore the roles and relationships of various actors involved, as well as the constraints and “systemic influences on deliberation and decision-making (Salter, 2013, p.

3). In this way the broader issues, trends, and interests that have shaped accreditation and the sector more broadly can be made visible (see: Nichols, 1980; Walker, 1998; Brommel, 2006; Bartley, 2007; Scott, Cafaggi & Senden, 2011, McCann & Ward, 2013). Therefore research on accrediting institutions is foundational to developing comprehensive theory of social service accreditation, which, as proposed by Brommel (2006, p. 8), can act as a foundation for “researchers to study the impact of the accreditation process on social service delivery or test the reliability and validity of the accreditation process in social services”.

Based on this rationale, this Major Paper provides a historical analysis of the formation and evolution of the Commission on Accreditation of Rehabilitation Facilities (CARF-International)—a prominent accreditation institution in the social services sector. In relation to the service system for street-involved youth in Vancouver, CARF-International is one of two approved third-party accreditation bodies (MCFD, n.d.). In 2013, approximately 90% of service providers funded by the MCFD were accredited by CARF-International, whereby the other approved institution, the Council on Accreditation (COA), accredited approximately 10% (MCFD, 2013). For this reason CARF-International was selected as the most relevant case study to my field of practice.

This research uses a historical case study methodology, and engages the literature on accreditation, and specifically accreditation institutions, to frame the analysis. However as discovered through the research process, CARF-International is an accrediting institution that spans numerous fields of social and health services, and originally emerged within the field of rehabilitation. For this reason, I also draw from selected literature on the welfare state, governance, and 'transnational private regulatory standards institutions', in order to offer additional perspective on the unique characteristics of this institution. This Major

Paper offers a unique perspective and contribution to the literature on accreditation in social services, as well as accreditation institutions more broadly.

LITERATURE REVIEW

This section provides an overview of the literature on accreditation and accrediting institutions, as well as selected literature on the welfare state, governance, and transnational private regulatory standards institutions. The purpose of this section is to focus on how accreditation and standards-setting institutions more broadly are talked about within academic discourse. The subsequent section provides a summary of the history of accreditation in rehabilitation and social/human services, primarily focused in the United States, in order to frame the emergence of the Commission on Accreditation of Rehabilitation Facilities (CARF).

Definitions of Accreditation

Accreditation, broadly, is described as “a system and process of reviewing programs against certain quality standards for the purpose of approving (or credentialing) the program” (Brommel, 2006, p. 14). The concept of accreditation emerged over a century ago in the United States within the fields of higher education and medicine, however the general function and purposes of accreditation—prior to the emergence of the term—can be traced back much earlier (see: Harcleroad, 1980; Walker, 1998; Brommel, 2006). By the mid-20th century accreditation had also emerged as a component of program evaluation in public administration—such as in social/human services—and subsequently as a

form of professional regulation in a wide variety of sectors, from fire services, to law enforcement, to early childhood education (Walker, 1998; Bowman, 2001; Apple, 2004)

Scriven (2000) identifies seven common features of accreditation (cited in Brommel, 2006, p. 16-17):

"Program Standards

1. A self-study report by the organization
2. A team of external assessors, usually peer volunteers
3. A site visit by the team of peer reviewers
4. A report on the organization with recommendations for improvement and for or against accreditation
5. An expert panel to review the report as well as any appeals created by the report
6. A final report and accreditation decision"

Points of difference or variation in accreditation have also been identified within the literature. For one, while accreditation initially emerged with a focus on management/organizational practices—and/or the credentials of management and leadership—many accreditation bodies now also includes standards related to outcome evaluation, and attempt to link process (business/organizational practices) to outcomes through empirical research (Worthen, Sanders, and Fitzpatrick, 1997, p. 123). As well, historically there have been two broad types of accreditation: institutional accreditation, which looks at the entire institution, as well as program specific accreditation, which looks at individual programs or departments within a broader institution (Worthen, Sanders, and Fitzpatrick, 1997, p. 128-129). However these lines have become blurred in contemporary accreditation bodies, which offer accreditation at either or both levels, often described as 'service network' or 'administrative network'.

The Institute of Medicine (2001) proposes three different models of accreditation that describe the ways in which accreditation fits into a system of governance. In the first model private accreditation is considered supplementary to government (public) regulation, meaning accreditation is considered to be beyond the standards set through government regulation, and therefore an organization or program would seek accreditation as a sign of superior quality (Institute of Medicine in Brommel, 2006, p. 18-19). The second model describes when private accreditation acts as a substitute to government (public) regulation, as for example when accreditation achieves 'deemed status' in state policy or legislation. In this case agencies that achieve accreditation do not also undergo certification by the state (Institute of Medicine in Brommel, 2006, p. 19). Another important aspect of this form of regulation identified by Ginsberg and Anderson (1985), specifically when it achieves statutory (required by law status), is that it provides the public with legal means of filing a grievance. In the third model, "the accrediting body does not create its own standards, but instead ensures compliance with standards that are determined by another entity" (Institute of Medicine in Brommel, 2006, p. 19). In this model the role of the private entity could either be as the accrediting body or the separate standards-development body.

Much of theoretical writing on accreditation is focused primarily on the different models and processes—i.e. how accreditation functions. The question of who is involved in developing and carrying out accreditation, namely the accrediting institutions and other affiliated actors, is often left underdeveloped. Much of the literature refers to 'professionals', 'experts', 'evaluators' and 'accreditation bodies', without including much detail (see works cited in Brommel, 2006, p. 15-18). As an example:

Accreditation has been categorized as...an expertise-oriented approach to evaluation...this approach depends on *professional expertise* to make judgment of meeting acceptable standards" (Worthen, Sanders, and Fitzpatrick in Brommel, 2006, p. 15).

Harclerod (1980) cited in Brommel (2006) describes accreditation programs in higher education as the result of interactions between a triad of actors: professional associations, who “require graduation from accredited programs”; state governments, who license both professionals and the institutions within which they work; and the federal government, who controls the overall process by recognizing accreditation bodies, and delineating the requirements for federal funding (Brommel, 2006, p. 22-23). However while Harclerod (1980) does identify the actors and institutions connected to the accreditation ‘system’, he does not provide much detail on the accrediting institution specifically.

Costs and benefits of accreditation

Stufflebeam (2000) in Brommel (2006, p. 14) describes the purpose of accreditation: “to assist some audience to assess an object’s merit or worth”. The benefits of accreditation, and specifically private or ‘third-party’ accreditation, generally relates to the impact on various actors. In terms of benefits to ‘the public’, Stufflebeam (in Brommel, 2006, p. 23) contends, “accreditation enables the public to make informed judgments about the quality of an organization”. Private accreditation also is described to benefit both the public and government as a means of “reducing the cost of oversight” because often the organizations themselves pay for the accreditation process, as opposed to a tax-funded state-run program (Institute of Medicine in Brommel, 2006, p. 24). More so, private accreditation programs can be “more flexible and responsive to change than governmental regulatory programs (Institute of Medicine in Brommel, 2006, p. 24).

In terms of the individuals or institutions that seek accreditation, accreditation systems can offer protection for a specific title or profession,

by defining a set of requirements related to education and experience to ensure a level of quality and consistency: “implies or guarantees that a member of that profession has attained a specific level of knowledge, expertise, and skill” (Brommel, 2006, p. 19). Organizations are also said to benefit as accreditation can act as a mechanism for legitimacy, which can encourage greater donations for non-profit organizations (Slatten, Guidry & Austin, 2011), and “respond to accountability demands” in general (Lee, McMillen, Knudsen & Woods, 2007, p. 52). There is also some research that suggests accredited service providers, in different types of health and human services, may have better outcomes than non-accredited providers (Bloom, 1996; Grachek, 2002; Dinehart, Manfra, Katz, & Hartman, 2012), and provide a useful resource for program managers to develop outcomes measurement processes (Carman & Fredericks, 2013).

The critiques and possible disadvantages of accreditation also relate to the impact on different actors. In relation to professionals/practitioners, accreditation has become a mechanism through which competition for recognition or legitimacy among different professional groups plays out. As a result the number of different accrediting bodies representing different groups has expanded over time, with potential for redundancy, misguided priorities, or resistance to change (Brommel, 2006, p. 33-36). Much of the literature on accreditation in human services also looks at the negative effects on front-line workers, who experience a reduction in their sense of agency, and an imposition of practices and priorities that do not reflect the values of their profession (Janz, 2004; Bates, 2005; Lirette, 2012).

For organizations, accreditation is often seen as labour intensive, resource intensive, and expensive, whereby “some argue that accreditation creates too much additional work that has little value or meaning”, and can be superficial (Institute of Medicine, 2001; Bowman in

Brommel, 2006, p. 30-31). Another critique is that private accreditation is not directly accountable to the public (Brommel, 2006, p. 30), and that “power rests not so much with the accredited, but with those who control the process of accreditation” (Malherbe in Brommel, 2006, p. 32). A concern raised by Nelson (1971, p. 165) in early writing on accreditation:

“The nature of standards depends upon the objectives of the standards setters...a question which must be asked is in whose interests the standards are set. Too often standards are set to do the following:

1. Protect the interests of organizations providing service.
2. Enhance prerogatives of administrators or professional staff.
3. Provide a minimum level of standards to preclude the growth of more adequate standards”.

Herein lies the argument for why greater attention should be paid to the accreditation institutions themselves, as within the overall service delivery system—specifically where private accreditation has become incorporated into public regulation through ‘mandated’ or ‘deemed’ status—the accrediting institutions hold significant influence on shaping the system. As described by Agocs & Brunet-Jailly (2010, p. 161), (performance) measurement is inherently political, occurs within a context of power relations, and is influenced by dominant values and ideologies. Yet within the literature on accreditation in the social and human services field, the focus has primarily remained on the effects on frontline workers (Janz, 2004; Bates, 2005; Lirette, 2012), or on the organizations/programs that seek accreditation (Slatten, Guidry, and Austin, 2011; Carman & Fredericks, 2013).

Accrediting institutions

The accreditation literature with a focus on institutions is somewhat less developed, however several studies described below offer a useful framework for developing a research methodology as well as for points of comparison between CARF and other institutions. Theory of accreditation

related to higher education in the United States proposes two main types of accrediting bodies. The first are 'institutional' accreditation bodies, which are administered regionally and accredits entire institutions (i.e. colleges and universities) (Nichols, 1980, p. 127; Walker, 1998, p. 10). 'Specialized' accreditation programs, are developed either by professional associations on their own, or by a coalition of professional associations with educators and/or regulators (Walker, 1998, p. 37).

This conception of 'specialized' accreditation has generally been applied as the framework to look at professional regulatory/accreditation bodies. The literature reviewed by Walker (1998) demonstrates how the governance structure of various accreditation institutions is affected by the shifting involvement/power of different interest groups, as well as outside influences such as economic conditions, government priorities and shifting societal values. His work provides a useful framework for research on accreditation institutions, however his findings are quite specific to developing a theory of specialized accreditation programs for professionals (individuals).

There are two main studies identified that offer a historical perspective of accreditation institutions of programs/services (vs. individual professional accreditation) in the field of social and human services. In 1980, Nichols published a doctoral dissertation on seven national social welfare organizations that ran accreditation programs for service providers, whereby she analyzes the historical development including the actors involved and governance structure of the organizations. Nichols (1980, p. 20) applied the lens of self-regulation and social control to accreditation, using the following definition: "Self-regulation to assure public confidence and support and to improve the quality of organization performance and service" (from Meek, 1977, p. 2783) Of the seven programs, only one was established directly as an

accrediting body; the other six programs were established within provider associations to help promote and legitimize their members, and respond to concerns of standards and quality control (Nichols, 1980, p. 27).

Through this research Nichols (1980, p. 53) demonstrated that the impetus to develop standards came from at least three groups: "professional leaders in the field, the member agencies, and external sources such as funding agencies and the government". In terms of the professional leaders, according to Nichols (1980, p. 64) the motivation to develop standards and accreditation programs was interlinked with the desire to develop national associations to represent the organizations or communities they represented. Both of these objectives were seen as ways to legitimize their cause or profession, and "as professionals, they were aware of the need for standards and quality control" (Nichols, 1980, p. 64). Similar motivating factors were found within the broader member agencies, as well as a desire for clarity around what the requirements were to become a member of the national associations (Nichols, 1980, p. 67). The external forces that played in were broad, including economic and social forces, for example: "post-war recovery is frequently accompanied by some re-evaluation of goals and directions" (Nichols, 1980, p. 69). Similarly during the post-war era, the increased role and funding from government to provide social welfare services in partnership with the private sector, also created additional pressure for accountability mechanisms (Nichols, 1980, p. 70).

The majority of Nichols' (1980) analysis is focused on the impact of accreditation and standards, as opposed to the specific accrediting institutions (beyond their formation), however she concludes by highlighting the most significant trends within the institutions analyzed: "pressure to make accreditation a condition for receipt of funding, a trend away from 'in-house' and toward third-party accrediting, and

concern to minimize the cost and maximize the benefits of accrediting programs” (Nichols, 1980, p. 3-4).

Brommel's (2006) study of the Council on Accreditation (COA) is uniquely positioned as an in-depth look at the historical evolution of an accrediting institution in the social services sector. As described by Brommel (2006, p. 9), the purpose of the study is to “examine the context in which COA developed, the assumptions behind its practice, and its impact on social service agencies... so that social workers and program evaluators may apply the knowledge gained through this research to understand the historical, philosophical, and theoretical basis of accreditation”. To frame this research Brommel positions accreditation as a form of program evaluation, and the COA as a specialized accreditation program (see: Walker 1998). Brommel (2006) provides a thorough descriptive overview of the evolution of the COA in terms of the governance structure and leadership of the organization, policy and standards development, as well as the relationship between the COA and other actors/institutions.

Through this study Brommel (2006) also holds the case study of the COA up against the literature on accreditation, and specifically specialized accreditation institutions and accreditation within the literature on program evaluation. In this way Brommel explores the differences between accreditation developed from within a professional association, versus the COA, which did not develop formal relationships with relevant professional associations until later years. According to Brommel (2006, p. 256): “the findings suggest the possibility that the absence of a formal relationship with the professional social work organizations may have been a contributing factor to the challenges COA faced in achieving legal recognition and marketing to prospective service agencies”. Brommel (2006) finds some agreement as well as

incongruity with the current literature on program evaluation, and she suggests: "the current theoretical literature in program evaluation should be updated to reflect the variety of current accreditation models and practices" (Brommel, 2006, p. 261).

However while Brommel (2006) does not focus much of her theoretical analysis on the governance and structure of the organization, the historical overview of the COA provides several significant parallels to the evolution of the Commission on Accreditation of Rehabilitation Facilities (CARF). The COA was initially formed through the collaboration of two industry associations – the Family Service Association of America (FSAA) and the Child Welfare League of America (CWLA), as an accreditation body for their members. As the Board was composed of selected representatives from the field of social services, one of the stated objectives of the COA was: "to make concerted efforts to have the social service model become as widely accepted as individual licensing and medical models" (COA, 1978 cited in Brommel, 2006, p. 153). In this way a primary purpose of the COA was to provide an alternative accreditor to the alternative, medical model approach to accreditation and standards.

A joint Board formed by representatives from the two organizations originally governed the COA, and later it was decided that an independent 25-member Board of Trustees would be formed, with six representatives from each of the associations, one representative from a joint FSAA-CWLA agency, and then twelve national organizations were asked to appoint one representative (Brommel, 2006, p. 151-152). Eventually, these organizations with appointed representatives became 'sponsoring organizations', and the Board began to actively seek further 'sponsoring organizations' in order to broaden the base of support for the organization, and help support the spread of COA accreditation

(Brommel, 2006, p. 155). Initially, the role of the Board of Trustees was policy-setting, with significant involvement in setting the standards, developing the accreditation process, approving accreditation decisions, as well as marketing and business development (Brommel, 2006, p. 154-155).

By the late 1980s and early 1990s, issues related to the size and function of the Board of Trustees began to emerge. In 1989 a Board policy-review committee recommended to downsize, to give more power and responsibility to the CEO, and to focus more on more high-level governance of the COA (Brommel, 2006, p. 167). In the mid-1990s, the Board of Trustees engaged in a strategic planning process and recommended:

“The Board should be more mission-oriented and members should be chosen based upon the mission and strategic initiatives of COA. The board should also be small enough to be change- and action-oriented. The board should define strategic issues and goals and hold management accountable for attaining those goals. Members of the board should help with advocacy and fundraising” (COA, 1994, cited in Brommel, 2006, p. 172).

Through both of these recommended changes, proposals for how to maintain the involvement and connection to their constituency and the sponsoring organizations were discussed. In the late 1980s a ‘Professional Advisory Group’ was proposed, which “would be responsible for recommending the standards for accreditation to the CEO for approval by the Board” (COA referenced in Brommel, 2006, p. 168). In the mid- to late-90s a similar ‘Committee of Ex-officios’ was discussed. In 2005 a major change was implemented when sponsoring members “no longer comprised the majority of seats on the board, and instead formed a separate sponsor advisory council with three seats on the board” (Brommel, 2006, p. 174).

Overall, Brommel’s (2006) historical analysis of the Council on Accreditation (COA) provides many useful parallels and theoretical considerations for my research on the Commission on Accreditation of

Rehabilitation Facilities (CARF). At the same time, in several ways Brommel's work, as well as the broader literature on accreditation does not provide a complete framework for my research. Firstly, while some of the literature on accreditation draws connections between accreditation and broader social, political and economic processes (ex. Janz, 2004) the literature on accreditation institutions does not contextualize or interrogate the evolution of governance and business practices of accrediting institutions. Secondly, based on the wide scope of CARF's program areas and products, CARF does not fit cleanly within the models outlined within the literature on accrediting institutions (i.e. Walker, 1998; Brommel, 2006). For this reason I draw from a range of literature related to the welfare state, regulation, and governance in order to provide a broader frame for this Major Paper.

Public welfare services

Based on the role and relationship of CARF within the social and human services sector, the organization has undoubtedly shaped and been shaped by the changing nature and scope of the welfare state—i.e. the funding and provision of public services—as well as broader global political and economic trends. These same factors have impacted individual service providers and programs, as well as the broader landscape of human and social services.

As has been demonstrated and analyzed by numerous scholars (see: Gelger & Wolch, 1986; Brodie, 1996; Griffin Cohen, 1997; Harvey, 2005), from approximately the 1980s onwards, in the United States and elsewhere in the Western world, the funding and scope of public welfare services has been in decline. Numerous disputed concepts such as

privatization, globalization, liberalization (and neoliberalization), and deregulation, have emerged as “ways of naming the process that point to this dislocation of place of the (welfare/national) state and its associated ideas of public interest and public services” (Newman & Clarke, 2009, p. 69). I will take up some of these ideas below, however important to note through this transformation are three important trends.

The first trend is a general “shifting of public service responsibilities to the private sector”, through a limited pool of government funding (Gelger & Wolch, 1986). A major effect of this, as described by Newman & Clarke (2009, p. 90), is the establishment of “markets and market-mimicking devices into the coordination of public services”. With a limited pool (and often decreasing) government funding it creates a competitive market for private service providers.

The second trend also plays into this competition, and relates to a major component of CARF standards – performance/program evaluation. Governments, as well as other funders, are seeking the greatest ‘return’ on their investments, and therefore private service providers must constantly look for ways to provide better outcomes for less money. Private service providers—which have traditionally included a bulk of not-for-profit organizations—have faced increasingly prescriptive funding requirements, forcing “agencies to restructure their operation to address priority needs...amalgamate boards...be more cost-effective” (Miller, 1998, p. 410). The overall shift has been to bring business practices and principles into public service funding requirements (Barzelay, 2001). As described by Newman & Clarke (2009, p. 82-83):

“Provider organizations are invited to imagine themselves as a business...to be ‘business-like’ in the way they manage themselves...identifying and improving the product; mapping competitors and collaborators; assessing the market; planning investment; capturing and satisfying customers---becomes a framing device for organizational decision-making. Senior figures in organizations are invited to understand themselves as CEOs, strategic managers, or ‘leaders’...the development of senior, strategic, innovative or

even transformational management is one of the long-term and now deeply embedded effects of this process".

The third trend, which is also central to CARF's work, is the increasing focus and pressure from government to ensure accountability for the funding that is dispersed to the private sector. While this relates to the second trend of striving for better performance and outcomes, it is also about ensuring that funding is used for its intended purposes. Brunet-Jailly & Martin (2010, p. 21) describes this as a fundamental aspect of the 'normative' framework of Western democracy: "accountability of government to its constituents is fundamental...and performance measurement and management enable accountability to be determined".

While many scholars have demonstrated the merits and value of performance/program monitoring (ex: Aguinis, 2009; de Leeuw & van den Berg, 2011), Agocs & Brunet-Jailly (2010, p. 161) remind us that measurement is inherently political, occurs within the context of power relations, and is influenced by dominant values and ideologies. This is echoed by Brodtkin (2011, p. 273), who challenges what she describes as "an implicit assumption of the performance-based approach to management" whereby "what counts" is assumed to be obvious or apolitical. For this reason, this Major Paper aims to draw connections between the growth and development of CARF, and these broader factors.

'Newly emerging infrastructure' and transnational private regulatory standards institutions

As demonstrated above, the literature on accrediting institutions is somewhat limited. More so, the focus tends to remain on the role or effects of the accrediting institution with the field of accreditation. Further,

based on the position that measurement—and thus accreditation—is political by nature and influenced by dominant values and ideology, I look to broader literature on regulation in order to contextualize the historical evolution of CARF. This section begins by placing CARF within the larger body of literature on regulation. From here I identify two key areas of discourse that relate to CARF, and will be applied in the analysis of this Major Paper.

To begin, I posit that CARF can be considered a 'transnational private regulatory standards institution'. CARF performs accreditation in numerous countries around the globe, and fits with the definition of transnational: "their effects cross borders, but are not constituted through the cooperation of states as reflected in treaties" (Scott, Cafaggi, & Senden, 2011, p. 3). CARF is also private, as it is not part of government, and is governed by an independent Board of Directors. CARF is a regulatory body in the sense that it "sets and enforces standards for performance" (Bartley, 2007, p. 302). There exists a distinction between regulation by legal authority and voluntary or supplementary regulation (see Binder, 1960, p. 13; Black, 2008), however CARF is involved in both through the 'mandated' and 'deemed' status that CARF accreditation has attained in multiple states and provinces.

The CARF standards are a set of agreed upon rules and norms related to the technical or other qualities of a system of production (Salter & Salter, 1997, p. 79), and they are regulated through some form of "implementation and enforcement...legal or non-legal" (Black, 2008, p. 139). Further, CARF is an institution, as a "location where deliberations about public issues take place" (Salter, 2013, p. 2), and where "coalitions of non-state actors codify, monitor, and...certify firms' compliance with...standards of accountability" (Bartley cited in Scott, Cafaggi, & Senden, 2011, p. 3).

Two major themes, which have been significantly researched and debated in regards to regulation are the notions of 'public' versus 'private', as well as local, or (nation) state-based, versus global or international. As proposed by Levi-Faur (2005, p. 202):

"It is suggested that the notion of a new order...goes beyond privatization and includes an increase in delegation to autonomous agencies, formalization of relationships, proliferation of new technologies of regulation in both public and private spheres, and the creation of new layers of both national and international regulation".

In regards to the first theme, the concept of 'privatization' is often used to describe the overall increasing role and influence of private actors in regulation (and elsewhere). This idea is present in the literature on regulation, for example Mattli & Woods (2009) provide a framework to explore how regulation has been 'captured' to varying degrees by private actors. However according to Brunet-Jailly & Martin (2010, p. 8-9) in broader public policy discourse, there has been a shift away from a focus on formal structures and institutions of government to the wider frame of 'governance'. This demonstrates a recognition from scholars of the various processes through which non-state actors participate in decision-making, wield power and authority, and in turn influence public policy (see also Young, 2012, p. 3-4).

This approach is more consistent with a bulk of literature on regulation and governance, whereby these new processes and structures through which non-state actors participate in governance invites us to reformulate the meaning of 'the state'. Salter & Salter (1997) propose a "newly emerging infrastructure", and Sassen (2008, p. 61) uses the concept of "specialized assemblages" to describe the new reality that resembles more of a network of relationships and interactions, as opposed to static and separate 'public' and 'private' entities.

This relates directly to the second theme, the shift from domestic to global governance, whereby the boundaries of the nation state become

blurred, and are often traversed by the 'networks' of governance described above. More so, regulation has been identified as a key example of these new global 'assemblages'. According to Sassen (2008, p. 61), in recent years there has been a multiplication of specialized global assemblages, that continue to be incorporated or connected to national/local institutions, but also cut across boundaries, and "are no longer part of the 'national' as historically constructed". These new levels and forms of political organization are not static, and they are held together—or assembled—by a variety of actors and institutions (see McCann & Ward, 2013, p. 5).

Within the discussion portion of this Major Paper, I will explore how these themes within the literature on regulation and governance relate to the historical evolution of CARF.

METHODOLOGY

This Major Paper uses a historical case study approach to research the formation and evolution of CARF-International, a prominent private accreditation institution in the social and human services sector. As further elaborated below, the theoretical rationale for researching an accrediting institution is based on the following assumptions from the literature review. First, accreditation is political, and framed by power relations and dominant ideologies (see: Brunet-Jailly, 2010). Second, accrediting institutions act as a forum through which the various interests and political, economic and cultural objectives of the actors involved are contested (see: Bartley, 2007). As such, a close examination of the formation and evolution of an accrediting institution is a forum to gain unique insight: "In

studying actors, you focus on those individuals, groups, organizations, governmental units and corporate bodies that do things to affect the fate of public issues; in studying institutions you focus on the constraints operating on these same actors...and the systemic influences on deliberation and decision-making" (Salter, 2013, p. 3).

According to Walker (1998), "institutionally oriented historical studies" can support better decision-making through "institutional memory" for individuals elected to governing boards "who typically possess little formal preparation and who do not expect to occupy their positions for more than a few years" (p. 32). More so, Walker (1998) describes the study of one specific accreditation institution as making a contribution to a broader picture of the issues and trends that may or may not be common to other accrediting bodies, such as "participating from private (for-profit) interests; operating in an environment with competing accreditors...and balancing the need for rigor, standardization and quality against the interests of innovation, flexibility and diversity in the development of accreditation criteria" (Walker, 1998, p. 33).

The basic premise of Brommel's (2006) study on the Council on Accreditation (COA) is that while the majority of social service professionals, front-line workers, and managers are affected by accreditation, there is a general lack of knowledge and understanding regarding who sets the standards and why particular standards are important (Brommel, 2006, p. 7). Therefore the rationale for Brommel's (2006, p. 8) study is to address the lack of information available to workers and agencies on the history and theory of accreditation, which can be provided through an in-depth look at "the factors that led to the formation, and influenced the development and evolution" of a prominent accrediting institution.

Within the literature on accrediting institutions, Walker (1998, p. 34) states that while several national specialized accreditation bodies have documented histories, “generally these accounts have been brief...and have not been the type of comprehensive work extensive enough to provide more than a very shallow treatment of major events and issues”. From here, Walker (1998) proposes a framework to study the development of a specialized accreditation body, which forms the basis for his research on the International Fire Service Accreditation Congress, and is also adapted by Brommel (2006) for her historical analysis of the Council on Accreditation (COA).

The literature on ‘transnational private regulation’ also reinforces the value of studying a specific regulatory (i.e. accrediting) institution, in order to develop theory and knowledge of the wider field of accreditation and social/human services. Salter (1998, p. 163) describes standards setting as “the housework of capitalism”, whereby regulatory institutions represent “the detailed implementation of both policy and politics”. According to Salter (2013, p.3):

“In studying actors, you focus on those individuals, groups, organizations, governmental units and corporate bodies that do things to affect the fate of public issues; in studying institutions, you focus on the constraints operating on these same actors...to the systemic influences on deliberation and decision-making”.

Although actors often have “different, and often conflicting incentives for creation and implementation” of a regulatory regime (Cafaggi, 2011, p. 31), many scholars advocate an in-depth look at the emergence and development of regulatory institutions, while simultaneously “treating it as an outcome of broader conflicts about the power of states, markets, and civil society” (Bartley, 2007, p. 299; see also McCann & Ward, 2011, p. xvii; Scott, Cafaggi & Senden, 2011, p. 6-7).

Based on the above-mentioned rationale for research on the formation and development of an accrediting institution, this major paper

utilizes a historical case study approach. This mode of inquiry is useful when “the purpose of research is hypothesis generating rather than hypothesis testing, when internal validity is given preference over external validity, when insight into causal mechanisms is prioritized over insight into causal effects, and when propositional depth is prized over breadth” (Gerring, 2007, p. 66). This case study is exploratory, with the primary objective to produce insight into the workings of this particular regulatory institution in order to “attempt to gain better understanding of the whole by focusing on a key part” (Gerring, 2007, p. 1). The means for constructing validity is therefore based on *external validity*, through analytical generalization, as I will seek to “generalize a particular set of results to some broader theoretical propositions” (Yin, 2009, p. 43). This research followed the six stages of the case study process outlined in Figure 1.

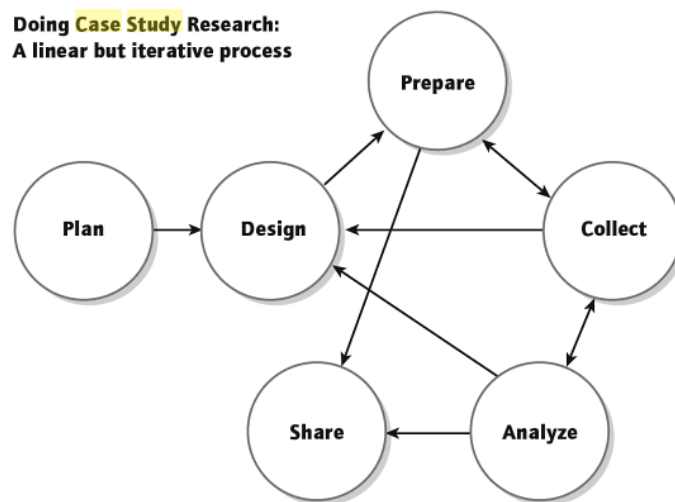


Figure 1: Case Study Research Process (Yin, 2009, p. 1)

The sources of information for this study were personal interviews as well as primary and secondary literature including news media publications, archival materials, and various other available sources such as corporate tax filings and annual reports. The primary and secondary

literature was collected through Internet search engines, academic databases (i.e. Proquest), and news media databases (i.e. Factiva).

The initial interview participants were identified based on a review of the literature and public information from CARF-International. From here, a process of snowball sampling took place. In total seven interviews were conducted. Four participants were identified individually through initial research and recruited directly, and three participants were identified through snowball sampling, and were contacted through a referral by the initial participants. Participants included various (primarily retired) professionals who have either been involved directly with CARF, as Board members or employees, or have worked in the field and had some connection to the organization.

The interviews were conducted over the phone, recorded, and then transcribed. The data has been stored in private files, will be kept for two-years, and then destroyed. Participants were given full control over the degree of privacy surrounding their participation, and it was decided to maintain the anonymity of participants within the Major Paper.

The snowball sampling research method was effective for this project, as it was quite difficult to identify and connect with individuals who had been associated with CARF-International for several reasons. First, there is limited literature or media sources that named individuals related to the organization, generally documents produced by the organization are authored by 'CARF-International'. Secondly, for the early years (1950s-70s) there are limited digitized documents available, and many involved in CARF during this time period have passed away. For individuals connected to the organization more recently, it was difficult to identify and gain trust of potential interviewees. For this reason snowball sampling was very helpful to gain access to knowledgeable sources. At the same time this research method does limit the range of perspectives

included in the research, as individuals who are connected are more likely to have a similar perspective or be involved in on aspect/sector of CARF's work.

The data from the interviews and literature search was initially organized into chronological order, and then broken up into three rough time periods, based on the three phases of leadership of the organization. The data was then organized into categories—the events that occurred in the broader sectors related to CARF, and the events that occurred within/by CARF (broken loosely into subcategories of: Who? What? Where? When? Why?). This format of organization was adapted from the guiding questions proposed by Brommel (2006, p. 10-11) [as adapted from Walker (1998)]:

1. “What were the motivating factors that led to the formation of the institution?”
2. What were the major events and milestones in the institution's history and the context in which they occurred?
3. What shaped the development and nature of the institution's governance and organizational structure?
4. How did the policies and practices of the institution develop and change over time?
5. What were the significant challenges and barriers faced by the institution?
6. What were the roles and relationships among the institution's key leadership and stakeholders?”

Key themes were then identified from the literature review, and the data was analyzed against these themes. Based on this process, seven themes emerged as most relevant to the case study of CARF-International.

BACKGROUND: THE EMERGENCE OF STANDARDS & ACCREDITATION

Rehabilitation – From a new field of medicine to a ‘facilities movement’

The origin of rehabilitation facilities (or 'centers') traces back to the roots of the concept of 'rehabilitation'. While certain programs for the physically handicapped emerged as early as the mid-19th century, the notion of 'rehabilitation' generally took hold in the early 20th century, and the movement began in earnest around the 1930s. By the mid-1960s, when the *Commission on Accreditation of Rehabilitation Facilities* was formed, the field of 'rehabilitation' included "three main tributaries...advances in the science of physical medicine; treatment centers offering services in the areas of physical therapy, occupational therapy, speech therapy, etc.; and sheltered workshops, homebound employment programs, and vocational training projects" (Roberts, 1957, p. 9).

The emergence of the first two tributaries is closely interlinked. The first programs for the physically handicapped grew from the combined effort of local voluntary groups, created by individuals affected by physical disabilities as well as physicians, who "became concerned with the need for specialized services for orthopedically handicapped persons" (Roberts, 1957, p. 1). From as early as the mid-1800s, a scattering of services aimed at 'rehabilitation' of the physically disabled emerged both within medical practice and institutions, as well as a variety of programs and facilities initiated by said voluntary groups (Roberts, 1957, p. 1-3).

Beginning in the 1930s, and intensifying through the end of the Second World War, the demand for rehabilitation services continued to grow. Federal and State expenditure on health and welfare expanded significantly, and the voluntary sector also grew in terms of both organizational capacity and funding, with the establishment of multiple National advocacy groups such as: United Cerebral Palsy, National Society for Multiple Sclerosis, and the National Paraplegia Foundation

(Roberts, 1957, p. 5). Through this increase in demand and resources, the field of rehabilitation medicine emerged as a broadened and more comprehensive approach to treatment.

Relatedly, complimentary professional fields became more established in the early- to mid-20th century, such as physical and occupational therapy, speech therapy, psychological counseling, prosthetics and orthotics, and more (Verville, 2009). As such, 'rehabilitation' services were established both as specific units or departments in hospitals, as well as some stand-alone facilities with a spectrum of professional services.

Within this expanded approach to treatment—and a generally more holistic understanding of health and wellness—the third tributary of rehabilitation also emerged in the form of vocational rehabilitation services. Amplified by the volume of disabled veterans returning home to the United States, pressure grew to provide opportunities for people with disabilities to participate meaningfully in society. Thus a third realm of 'rehabilitation' and associated facilities materialized in the form of sheltered workshops and vocational training programs. Overall these three tributaries of rehabilitation became somewhat interlinked as a priority of government policy and funding, as for example with the *LaFollette-Barden Act* of 1943, which added physical rehabilitation to the goals of federally funded vocational rehabilitation programs, providing funding for certain health care services relevant to vocational rehabilitation. The ethos of this period was describe by as follows by Ms. Mary Switzer in 1957, who was at that point the Director of the U.S. Office of Vocational Rehabilitation:

"We live in a nation which is redefining its attitude toward disability. For the first time in the long history of mankind's subjection to disease and injury, a society has begun to develop which refuses to accept the inevitability of invalidism and uselessness. More and more disabled people are demanding another chance...this is part of the pattern of excitement and progress of this age in which we live" (Switzer, 1957, p. 313-314).

Through the growth of rehabilitation services, what is often referred to as the 'facilities movement' began to take hold in the mid-1950's. At this time, more and more stand-alone rehabilitation centers/facilities had been established in the United States, increasingly supported by state policy and funding. As described by Henry Redkey in a report published by the Office of Vocational Rehabilitation in 1959: "There are about 100 rehabilitation centers in the United States...[and] recent Federal legislation has given impetus to the establishment of more centers" (p. 1). In 1959 the *Housing Act* "authorized the Commissioner of the Federal Housing Administration to insure mortgages for the construction of rehabilitation or qualified proprietary nursing homes" (Haldeman, 1963, p. 115), and in 1963 the *Mental Retardation Facilities and Community Health Centers Construction Act* authorized federal grants for the construction of public and private non-profit community mental health centers.

However it was the *Vocational Rehabilitation Amendments* of 1965 that are seen as the key turning point in the facilities movement. These amendments authorized new federal funding for the construction of rehabilitation facilities and expansion of rehabilitation programs, and as described by one interviewee who worked at the Office of Vocational Rehabilitation: "we went home from work one night and we were a \$100-million program, and we came back the next morning as a \$300-million program, with all of these tremendous rehab facilities and authorities that were brand new in those amendments" (Participant 1). According to Pacinelli (2010, p. 3) the amendments also introduced the term 'rehabilitation facilities' into federal legislation, as an all-encompassing term to replace 'centers' and 'workshops'.

Ms. Mary Switzer and the Office of Vocational Rehabilitation (Vocational Rehabilitation Administration)

One of the most influential actors in the development of the rehabilitation sector and the 'facilities movement' was Ms. Mary Switzer. She was a government leader in vocational rehabilitation, acting as the Director of the Office of Vocational Rehabilitation (from 1950-63), and the Commissioner (1963-67), when the office became its own federal agency, as the Vocational Rehabilitation Administration. As described by Ralph Pacinelli (2010, p. 2): "she guided the program from the federal office for 17 consecutive years, that brought expansion and development in matters of legal authority, programmatic coverage, and fiscal stability".

From the beginning of her tenure at the Office of Vocational Rehabilitation (OVR), Ms. Switzer supported the development of the rehabilitation sector in numerous ways. In the early 1950s, Ms. Switzer worked to support partnership and policy development between the state directors of Vocational Rehabilitation, whereby Federal (OVR) staff were assigned to support meetings—by preparing notices, recording and distributing minutes—which ultimately led to the formation of the Council of State Administrators of Vocational Rehabilitation (Pacinelli, 2010, p. 3).

Under her tenure at the OVR, the first major piece of legislation to support vocational rehabilitation was passed in 1954. The *Amendments to the Rehabilitation Act (1954)*, provided authority and funding to the OVR to initiate a research program, with several different streams of grant money to support the development of rehabilitation services. As described by Ms. Switzer at the Institute on Rehabilitation Center Planning in 1957: "Through the special projects [grants] program, 74 research projects and demonstration programs have been approved, totaling nearly \$3 million, to seek new knowledge and better methods in rehabilitation" (1957, p. 315). Through the 'expansion grant' program that

was also authorized through these amendments, further funding was made available to support the development of rehabilitation centers and facilities (Switzer, 1957, p. 315). As described by an interviewee (Participant 1): “There were many ways in which rehabilitation services, both medical and vocational, were delivered...It [the facilities movement] was just a way—her vision—for the total community to participate in the delivery of quality services, towards quality outcomes”.

From 1952 to 1957, the Office of Vocational Rehabilitation (OVR) worked collaboratively with the Conference of Rehabilitation Centers to further the advancement of rehabilitation centers and facilities. Together, the OVR and the Conference of Rehabilitation Centers hosted numerous workshops, conferences, and meetings, culminating in the Institute of Rehabilitation Center Planning in Chicago in 1957. The Institute hosted presentations by the most prominent actors in the field, including Ms. Mary Switzer, as well as Dr. Howard Rusk, who is considered by many as the ‘father’ of rehabilitation medicine. Also included were several individuals who would later become involved with the formation of the Commission on Accreditation of Rehabilitation Facilities (CARF), such as E. J. Desjardins (one of CARF's original Trustees), and Charles Caniff, the first Executive Director of CARF.

Through nearly all of the projects funded by the OVR, as well as the various committees and research programs established by the OVR, there were significant opportunities for involvement by actors and institutions from within the private sector. As described by an interviewee: “She [Ms. Switzer] believed strongly in this public-private partnership”. According to this interviewee, a significant portion of services at that time was delivered by the not-for-profit sector, and therefore Ms. Switzer saw the vocational rehabilitation program as a partnership between government and service providers. This notion of partnership was put into practice through what

was colloquially dubbed the 'Iron Triangle', whereby representatives from both the Legislative and Executive branches of government, worked collaboratively with representatives from the National Rehabilitation Association (NRA), a prominent trade association, The work of the 'Iron Triangle' is described by Pacinelli (2010, p. 3) as "pivotal to the historic legislative gains made in 1954 and 1965.

This approach was also clear when the impetus to develop standards and accreditation emerged within the facilities movement. During her presentation at the 1957 Institute, Ms. Switzer (1957, p. 322) stated:

"Already in the Conference of Rehabilitation Centers we have heard demands for some kind of certification or accreditation of centers...those responsible for spending money, either public or private, in centers cannot wisely disburse these funds unless they are assured that the center operates on acceptable standards. **The Conference of Rehabilitation Centers...may play a very important role in development of standards for the guidance of all who operate or use centers**".

Through the OVR research program initiated by the 1954 Amendments, the OVR, and later the Vocational Rehabilitation Administration (VRA) became the primary funding source for the development of standards and accreditation by the private sector.

The emergence of standards and accreditation in health, rehabilitation, and social services

Accreditation in the health and social services sector initially emerged in the medical field, whereby (U.S.) national standards for hospitals were initially established in 1944, and further advanced through the establishment of the Joint Commission on Accreditation of Hospitals (JCAH) in 1951. The JCAH was a collaboration of the major organizations representing hospitals and physicians in the United States, and became the first example of private accreditation standards incorporated into government regulation, as a requirement for hospitals to receive Medicare funding, since the inception of the Medicare program in 1965 (Stoltzfus Jost, 1995, p. 15).

Standards for the rehabilitation sector in the United States were developed mainly through the collaboration of two groups: “government agencies who purchase services or give grants...and the private associations of workshops and rehabilitation facilities and accreditation bodies” (Nelson, 1971, p. 164). The first standards related to rehabilitation were focused on sheltered workshops. A pamphlet published in 1944 by the U.S. Department of Labor included standards related to “organization and administration, working conditions, wage payments, buildings and equipment, and ethical business practices” for sheltered workshops (Bowman, 1970, p. 38). However these standards did not attract much attention, as they were not very specific, and workshops were not highly used or funded by state rehabilitation agencies (Nelson, 1971, p. 167).

Beginning in the 1950s, state vocational rehabilitation agencies became much more interested and supportive of workshops, and there was significant growth in the volume of workshops in the United States (Nelson, 1971, p. 167). According to an interviewee, “with the change in developing more facilities there was a lot of things that needed to be answered...there wasn't good health and safety standards, there wasn't occupational safety and health, there wasn't good fire inspection” (Participant 6). Then in 1954, the Rehabilitation Act Amendments granted research authority and funding to the Office of Vocational Rehabilitation, and government funding was then made available to support the development of standards for the field. States also became responsible to set eligibility guidelines for federal funding to workshops, thus some states began to develop their own standards, including California and New York (Nelson, 1971, p. 168)

The first major attempts to develop national standards came about in the late 1950s. In 1957, the National Institute on Rehabilitation Centers and the Conference of Rehabilitation Centers held their annual national

workshop with the theme of 'Administrative Guide Posts', with standards and accreditation as one of the three major topics to be addressed. Subsequently in 1958 the National Conference on Workshops was held, which also recommended the establishment of a study to formulate standards for workshops (Nelson, 1971, p. 170). From here, the Conference of Rehabilitation Centers and Facilities received a 1-year grant in 1959 from the U.S. Office of Vocational Rehabilitation (became the Vocational Rehabilitation Administration in 1963), with the goal to develop some form of standards for rehabilitation centers. As well, the National Institute on Workshop Standards (*see 'The role of ARC & NASWHP' below) began a 5-year project with similar intentions.

The first private agency to establish accreditation standards in the field of rehabilitation was Goodwill Industries of America in 1961, shortly followed by the American Foundation for the Blind that same year. The standards developed by Goodwill Industries focused specifically on agencies offering vocational rehabilitation for the handicapped, whereby the standards of the American Foundation for the Blind were directed at agencies serving the blind and visually handicapped. In 1966 Goodwill Industries, began to administer their standards through their own accreditation branch, whereby the American Foundation for the Blind created the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped in that same year in order to administer accreditation.

Standards in the aging services field also emerged in the early 1960's. In July 1964, the President of the American Association of Homes for the Aging announced a new national program to approve and accredit homes for the aged, nursing homes, and similar facilities. The program was developed and organized by a committee convened by the American Hospital Association, which included several other

organizations including the Association of Rehabilitation Centers (ARC), one of the founding organizations of CARF.

Another driver for the establishment of standards in sheltered workshops and vocational rehabilitation came from organized labour in the United States. This was in recognition of the lack of health and safety standards for facilities, or standards on “bidding practices, management, accounting or wages” (National Institutes on Rehabilitation and Health Services, nd, p. 5). Through a training program funded by the Vocational Rehabilitation Administration (VRA), the National Institute on Rehabilitation and Health Services facilitated a series of workshops and publications between 1965 and 1967, with involvement from various community and state-wide organizations, as well as the national facilities body – the National Association for Sheltered Workshops and Homebound Programs (NASWHP), as well as the American Federation of Labor—Congress of Industrial Organizations (AFL-CIO). This program culminated in a publication that outlined the recommendations from the perspective of the trade union movement for the development of standards for sheltered workshops (see: National Institutes on Rehabilitation and Health Services, n.d.).

The role of ARC & NASWHP in developing standards

The two organizations that collaboratively established the Commission on Accreditation of Rehabilitation Facilities (CARF) in 1966—the Association of Rehabilitation Centers (ARC) and the National Association for Sheltered Workshops and Homebound Programs (NASWHP)—also were involved in developing standards in the late 1950's and early 60's. The ARC was the largest (U.S.) national organization of medical rehabilitation centers at that time, and similarly, the NASWHP was

the largest organization representing vocational centers in the United States.

In 1957, the National Association for Sheltered Workshops and Homebound Programs (NASWHP) in partnership with the National Rehabilitation Association (NRA) received a grant from the U.S. Vocational Rehabilitation Administration (VRA) to support the establishment of a sheltered workshop institute that emphasized the need for standards. The organization that grew out of this relationship, "The National Institute on Workshop Standards" (NIWS) worked from 1958 to 1964 to develop a set of standards for sheltered workshops. The rationale of the NIWS was based on the following principle:

"Self-regulation would be better than government regulation by forfeit; the workshop movement itself was better equipped to develop evaluative standards and criteria; that the workshop movement could best formulate a basis for ongoing development of future standards for evaluation of workshop programs and could best implement such standards and criteria via a national accreditation program or by some other means" (Bernstein in Nelson, 1971, p. 170).

Similarly, in 1958 the Association of Rehabilitation Centers (ARC) began a project to develop standards specific to rehabilitation centers and facilities. The U.S. Vocational Rehabilitation Administration (VRA) also acted as the main funder for this project, with further support from the Association for the Aid of Crippled Children, Easter Seals Research Foundation, the National Institutes of Health, the National Rehabilitation Association, and the American Rehabilitation Foundation. Charles Caniff, who soon became the first Program Director of CARF, directed the project. The results were published in 1965, with six categories of standards—legal, organizational, patient care, personnel, plant and fiscal management—for medical, psychological and/or social, vocational and/or educational, or a combination of these services.

ESTABLISHMENT OF CARF (1966):

In September 1966, the Association of Rehabilitation Centers (ARC) and the National Association of Sheltered Workshops and Homebound Programs (NASWHP) incorporated the Commission on Accreditation of Rehabilitation Facilities (CARF) in the state of Illinois, as a not-for-profit organization. As described by an interviewee, "CARF came from a period of time, the 60s, and especially with the Rehabilitation Act Amendments of 1965, that focused on facilities – giving authority to facilities" (Participant 1). At that time, there was a sense within both organizations that there needed to be some level of quality standards established around how operations were set up, and how things were managed (Participant 6). More so, as the ARC and NASWHP were the two most prominent organizations representing facilities in each of vocational rehabilitation and medical rehabilitation, "the two organizations kind of wanted to send up a balloon to see if the interests of their constituencies could be bucked together...CARF was to be a trial balloon" (Participant 2).

The establishment of CARF was assisted by Ms. Mary Switzer, and through a five-year funding grant from the Vocational Rehabilitation Administration (Toppel, 1976, p. 19). According to Alan Toppel, who became the Program Director of CARF in 1969 "Ms. Switzer...had a visionary role in our establishment" (1976, p. 19). Through the funding and support provided by Ms. Switzer and the Vocational Rehabilitation Administration in the years leading up to 1966, the ARC & NASWHP had already carried out the majority of the process involved in developing the standards. Therefore "the first CARF standards manual was produced in the mid-60's as a result of the separate in-depth activities by the two organizations" (Toppel, 1976, p. 20). Each organization had already

developed “some standards for their own constituency, and CARF'S task was to bring those standards together” (Participant 2).

Within the articles of Incorporation for CARF, it was stated: “The first Board of Directors shall be nine in number” (Commission on Accreditation of Rehabilitation Facilities, 1966). At the time of incorporation, the ARC and NASWHP appointed six out of nine Trustees for the organization: E.J. Desjardins (Vancouver, Canada), who was the founding director of the G.F. Strong Rehabilitation Centre in Vancouver, Canada, and had also been a member of the Research Committee of the ARC in 1965; Howard G. Lytle (Indianapolis, IN), the National Vice President of Goodwill Industries; Jack C. Haldeman (New York, NY), an Officer of the U.S. Public Health Service, as well as a member of the Department of Health, Education, and Welfare's (HEW) Committee on Planning of Facilities for Rehabilitation Services,—a joint committee of the Public Health Service, the Vocational Rehabilitation Administration, and the Association of Rehabilitation Centers (ARC); J. Arthur Johnson (Washington, D.C.), the Executive Director of a community organization for the blind in Washington, D.C.; Gerald H. Fischer (Hot Springs, AR), a rehabilitation center Director who became President of the ARC in 1968; as well as Michael M. Galazan (Milwaukee, WI), the Executive Director of the Jewish Vocational Service in Milwaukee, Wisconsin.

At the first meeting of the Board of Trustees in September 1966, three more trustees were appointed to the Board, as voted on by the initial six members. The trustees were: Dr. William J. Erdman (Philadelphia, PA), a Professor and Chairman of the Department of Physical Medicine & Rehabilitation at the University of Pennsylvania; Leo Perlis (Washington, D.C.), the Director of Community Services Activities for the American Federation of Labor—Congress of Industrial Organizations (AFL-CIO); and

Dorothy Cantrell Perkins (Los Angeles, CA), the Director of the Rehabilitation Training Center at California State College.

The founding of CARF also was dependent upon the administrative support of the already well-established Joint Commission on Accreditation of Hospitals (JCAH) (see above description in 'The Emergence of Standards & Accreditation').

"They (ARC & NASWHP) didn't have any experience in putting together an accreditation program or function. And so they looked around, and at that time the Joint Commission (JCAH) was interested in becoming an umbrella body for various specialty accreditation programs. CARF came in (to the JCAH) and was the only separately incorporated body within the Joint Commission. Within the Joint Commission though CARF was called RFAT – the Rehabilitation Facilities Accreditation Program...CARF paid an administrative fee to the Joint Commission...in exchange for services such as accounting and human resources" (Participant 2).

Within this arrangement the Executive Director of the Joint Commission (JCAH) – Dr. John Porterfield also served as the Executive Director of CARF. He reported to both the Joint Commission's (JCAH) Board of Commissioners as well as the CARF Board of Trustees. ARF's founding in the state of Illinois was also rooted in this relationship with the JCAH—which was based in Chicago, Illinois—as CARF initially operated out of the office of the JCAH in downtown Chicago (Participant 2).

The first Program Director for CARF in 1966 was Charles Caniff, who was hired as an employee of CARF itself, and was at the time a prominent actor in the field of rehabilitation. Caniff had previously served as the Executive Director the Association of Rehabilitation Facilities (ARC), directing ARC's project to produce their 'Manual of Standards for Rehabilitation Centers and Facilities' in 1965, and serving as a representative on the same joint-committee as CARF Trustee Jack Haldeman – the Committee on Planning of Facilities for Rehabilitation Services (Department of HEW).

CARF officially began operations in 1967, and formally launched their accreditation program in 1968 (Bowman, 1970, p. 42). CARF adopted the following definition of a 'rehabilitation facility':

"A rehabilitation facility is an organizational and physical entity in which a soundly and ethically based program of integrated and coordinated services is provided. The services are directed toward the physical, mental, social, and vocational restoration and adjustment of handicapped, disabled children and adults. The services consist of evaluation, treatment, education, training and placement, and are provided by competent personnel especially qualified in the various phases of the rehabilitation process" (CARF, 1967; cited in Bowman, 1970, p. 44).

CARF's first surveyor, Bill

Henderson, carried out the first four 'test' surveys of rehabilitation facilities in 1968 (Participant 2).

- Purposes of CARF (1966)**
- a) "To promote and assist in the self-improvement of rehabilitation facilities through the provision of educational and advisory services with respect to standards;
 - b) To adopt and apply the initial standards approved by the original members in measuring and evaluating rehabilitation facilities for accreditation with respect to: Organization, types and quality of services, personnel, records and reports, fiscal management, physical plant, the efficiency of industrial activities when provided and such other factors as may be deemed consistent with the goals of the facilities to be accredited;
 - c) To seek advice and guidance from all appropriate sources in regularly reviewing and reevaluating standards and to promote and carry out studies for the purpose of expanding and elevating the initial standards in keeping with changing concepts and advancing professional knowledge and skills;
 - d) To cooperate with other organizations having similar or allied objectives and to take into membership such other organizations upon terms and conditions as may be mutually desirable;
 - e) To assume such other responsibilities and to conduct such other activities as are consistent with the administration of a program of educational and advisory services and a program of accreditation of facilities;
 - f) To carry out such programs in the United States of America, Canada and in such other countries as may be appropriate and feasible;
 - g) (**Added as an amendment in December 1966) This corporation is organized exclusively for charitable, scientific and educational purposes and no part of the net earnings of the corporation shall inure to the benefit of any private member, director, officer or other individual..."

Figure 2: Purposes of CARF (CARF Articles of Incorporation, 1966)

HISTORICAL EVOLUTION OF CARF

PHASE 1: Foundational years (late 1960s to late 80s)

Context

In November 1969, the Association of Rehabilitation Centers (ARC) and the National Association of Sheltered Workshops and Homebound Programs (NASWHP) formally merged as the International Association of Rehabilitation Facilities (IARF). Miss Switzer played a significant role in the merger, in helping to construct the framework for the agreement, and in “convincing the Boards of Directors that a certain critical mass in personnel and financial resources was needed to operate an effective advocacy agenda for member facilities” (Pacinelli, 2010, p. 3). The newly formed IARF thus became a significant representative voice for over 750 rehabilitation facilities in the U.S. and Canada (Pacinelli, 2010, p. 3). While government administration of these two broad groups of service providers—medical rehabilitation and vocational rehabilitation—remained separate, the general trends in policy and legislation were quite similar, as described below.

Throughout the late 60s and 70s, the role and volume of private service providers continued to grow, within both medical and vocational rehabilitation. On the medical side, the Lanterman-Petris-Short Act (1967) was signed into law in California, which set a precedent for modern mental health procedures in the United States, and specifically against mandatory institutionalization. This movement of ‘de-institutionalization’ was further reinforced through influential case law in the early 1970s (such as *New York ARC v. Rockefeller*). In this way there was a growth in demand for community-based service providers and facilities. Between 1971-73 approximately \$50-million was made available for community mental health centers through the Federal Medicaid reimbursement program (Kemp, 1996).

Throughout the 70s and 80s, the increase in funding and services related to medical rehabilitation, as well as the growing role of community-based service providers, coincided with an increasing impetus

from the U.S. Federal government for the establishment of standards and quality assurance mechanisms. In 1971 and 1972, amendments to the *Social Security Act* (which governs the Medicaid program) imposed some form of standards requirements for facilities in order to receive federal funds. For certain services, such as psychiatric rehabilitation for children and youth, the standards and accreditation by the Joint Commission on Accreditation of Hospitals (JCAH) were required, whereas with other types of services funded through Medicaid, different standards and accountability mechanisms were being developed. In 1975 further amendments to the *Social Security Act* expanded the availability of funds to purchase private or voluntary social services, and transferred the responsibility to the states for planning, quality assurance and 'programmatic accountability', which significantly expanded the demand for accreditation programs (Brommel, 2006, p. 90).

In 1981 the U.S. Federal Government authorized the Medicaid waiver program and specifically 'Medicaid Waiver 1915(c) – Home and Community Based Services (HCBS)', which gave states the option to "allow the provision of long term care services in home and community based settings under the Medicaid Program" (Centers for Medicare & Medicaid, 2014). This applied to an array of rehabilitation services including residential and day programs for mental illness or disabilities, for both children and adults. As described by an interviewee this "put a preponderance of very serious quality control on the state itself, so the state was scrambling for any mechanism to watch its programs" (Participant 6). The federal government would at times come around and do spot checks, and if the state was found to not be in compliance with the quality assurance requirements, they would request that money be paid back or impose a fine (Participant 6). This program further pushed

states towards imposing accreditation requirements on funded service providers.

There was also an expansion of government funding in the United States for vocational rehabilitation and disability services. In 1970, the passing of the *Developmental Disabilities Services and Facilities Construction Amendments* expanded the definition of 'disability' and authorized government funding for planning, services, and construction of facilities. The 1973 *Rehabilitation Act* also increased the grants available for states to fund vocational rehabilitation services. Similarly to with medical rehabilitation, the *Rehabilitation Act (1973)*—Section 101(a)(7)(B) and Section 401.43—delineated the responsibility of States to “mandate standards on all vocational rehabilitation facilities as a condition for accepting federal funds” (Etling, 1976, p. 1). Each State did however have the ability to set their own standards and accreditation programs.

As described, CARF was not the only organization that emerged to develop standards and administer accreditation. Since its inception CARF has been operating in competition with other private accrediting bodies, as well as with state-led accreditation, and other performance/quality monitoring options from within government. In the 1960s, the main alternatives to CARF standards and accreditation were the programs run by the state itself (with a wide range of complexity and oversight), the Joint Commission (JCAH) accreditation for medical rehabilitation providers, and the accreditation programs that had been developed by the provider associations for their members, such as (National) Goodwill Industries, and the American Foundation for the Blind.

In the early 1970s the Joint Commission (JCAH) also began developing new areas of standards, including long-term care, psychiatric services, ambulatory care, and more. According to an interviewee, “most mandates at the time came on the Joint Commission (JCAH) side for

medical rehabilitation, but if an organization had had an employment context, then if there was a CARF mandate it would affect them” (Participant 2). Goodwill Industries also continued to maintain a competing accreditation program, under which the local Goodwill chapters could become accredited, however they used a lot of the standards developed by CARF, according to an interviewee: “The CARF standards weren’t copyrighted or anything...the wording might have been a little bit different but the intent was pretty much the same, they just weren’t as extensive as CARF” (Participant 5).

New accreditation bodies also emerged in the late 70s and the 80s, including the Council on Accreditation (COA) in 1977, which was focused on child and youth services, and the Continuing Care Accreditation Commission (CCAC) formed in 1985 by the American Association of Homes and Services for the Aging (AAHSA; *now LeadingAge). However neither of these accrediting agencies was in direct competition with the standards and accreditation program that CARF had developed at that time.

CARF Leadership & Governance

In late 1968, Charles Caniff left CARF as the Program Director, and in early 1969 Mr. Alan Toppel took over in that position. At the time he had been acting as the Administrator for the Rehabilitation Institute of Chicago. Upon joining CARF Alan Toppel began reporting to Dr. John Porterfield, who was still the Executive Director of both CARF and the Joint Commission (JCAH). However in the early 1970s that relationship began to shift.

By 1971, the Joint Commission (JCAH) had a number of other accrediting groups that had joined their accreditation program, and thus Dr. Porterfield hired an Associate Executive Director for the Joint

Commission, in order to manage the associated accreditation programs. According to an interviewee, the CARF Trustees and Alan Toppel perceived this poorly, as they no longer had direct contact with Dr. Porterfield, who was quite knowledgeable about the CARF program (Participant 2). Paired with the fact that the administrative services of the JCAH were very expensive, this motivated the CARF Board of Trustees to separate from the JCAH, and in late 1971 the two organizations issued a joint statement to that effect (Participant 2).

In 1970, Alan Toppel brought in a second employee named Jack Nichols, who was hired as the Research and Education Association. Then in 1972, following the break from the Joint Commission, Alan Toppel became the Executive Director of CARF, and Jack Nichols moved into the role of Chief Operating Officer. Together, Mr. Toppel and Mr. Nichol lead the organization through the subsequent two decades.

In 1971 there was also a significant change with the CARF Board of Trustees, which grew from 9 to 15 members in that year, and added representatives from 'sponsoring member organizations'. The sponsoring organizations made a financial contribution (evolving over time from \$1200-\$5000 annually), in order for the right to appoint a representative to the Board of Trustees. According to an interview participant, the sponsoring organizations each appointed 1-2 members, "and then the Board itself would add an at-large component...to achieve more of a balance of interests and commitment, etcetera" (Participant 2). The Board hovered around 15 members until 1986, when it grew to 25 members, and continued to expand across the late 80s and early 90s.

Along with acting as the governing body of the organization, the role of the CARF Board of Trustees as described by Alan Toppel in 1976 (p. 20) was also "to approve the standards and revise the standards manual annually". According to an interviewee, as the Board matured, the

members wanted to take on a stronger role in the organization. As new representatives became involved into the 1970s, members expressed interest in having more input and being involved in a leadership function for different aspects of CARF's work (Participant 2). A series of Board committees were thus formed, for example: the Survey Procedures Committee would look at the procedures of doing a survey, the Standards Committee would take all of the recommendations from the advisory working groups and approve all of the standards, and the Accreditation Committee would approve all of the accreditation decisions (Participant 2).

As described by Terry Etling, an at-large member of the CARF Board of Trustees in the 1980s:

"I was the chair of the (Accreditation) Committee for CARF in 1989. I had to do a lot of reading, every survey that was done in the U.S. - I had to read and then vote on whether to go along with the recommendation. Every day in the mail I would be getting surveys, and we would meet by conference call and review them, not on a daily basis but a lot more frequently than the full Board met" (personal communication, October 24, 2014).

The full Board of Trustees would meet three times annually, however "there was a lot of work being done between the meetings by the committees" (Participant 3). Between meetings the committees would come up with recommended actions, then the full Board of Trustees would vote on whether to ratify the recommendations: "It was a very participatory process; a lot of input from a lot of people" (Participant 3).

During this period of Alan Toppel's leadership, interviewees describe the relationship between the CARF staff and the Board of Trustees as very open and collaborative. One interviewee stated: "All the staff could attend the Board meetings; the Board got to know all the staff...The door was always open – open around the finance, open around the Board meetings, open around the communication. Simply put it was a very transparent kind of situation" (Participant 6). Another interviewee explained: "We (the staff) would talk...and come up with some positions,

so that when we went to Board meetings we would lay out the issues and then make staff recommendations” (Participant 2). As such, staff worked very closely with the Board in governing CARF.

Evolution of the Board of Trustees (*select dates)

1971:

- 1 At-large Member; 13 Sponsoring Member Appointees
- **Sponsoring Member Organizations**
 - *International Association of Rehabilitation Facilities* (5 members)
 - *Goodwill Industries of America Inc.* (2 members)
 - *National Association of Hearing and Speech Agencies* (2 members)
 - *American Hospital Assn. – Section on Rehabilitation and Chronic Disease Hospitals* (2 members)
 - *National Easter Seal Society for Crippled Children and Adults* (2 members)

1979:

- 3 At-large Members; 10 Sponsoring Member Appointees
- **Sponsoring Member Organizations**
 - *American Hospital Association* (2 members)
 - *Association of Rehabilitation Facilities* (2 members)
 - *Goodwill Industries of America* (2 members)
 - *National Easter Seal Society for Crippled Children & Adults* (2 members)
 - *National Rehabilitation Association* (2 members)

1984:

- 8 At-large Members; 6 Sponsoring Member Appointees
- **Sponsoring Member Organizations** (1 member each)
 - *American Hospital Association*
 - *American Occupational Therapy Association*
 - *Goodwill Industries of America*
 - *National Association of Jewish Vocational Services*
 - *National Easter Seal Society*
 - *United Cerebral Palsy Associations*

1989:

- 18 At-large Members; 18 Sponsoring Member Appointees
- **Sponsoring Member Organizations** (1 member each)
 - *American Academy of Neurology*
 - *American Academy of Physical Medicine and Rehabilitation*
 - *American Hospital Association*
 - *American Occupational Therapy Association*
 - *American Physical Therapy Association*
 - *American Psychological Association*
 - *American Speech-Language-Hearing Association*
 - *Association of Rehabilitation Nurses*
 - *Federation of American Health Systems*
 - *Goodwill Industries of America*
 - *Intl. Association of Psychosocial Rehabilitation*
 - *International Association of Addictions Treatment Providers*
 - *National Association of Jewish Vocational Services*
 - *National Association of Private Residential Resources*
 - *National Association of Rehabilitation Facilities*
 - *National Easter Seal Society*
 - *National Rehabilitation Association*
 - *United Cerebral Palsy Associations*

Figure 3: CARF Board of Trustees (1970-1990)

Operations & Business Practices

During this first phase of CARF's operations, "we spent a lot of time looking at different ways of doing things" (Participant 2). The initial five-year start up grant from the Vocational Rehabilitation Administration (VRA) became a nine-year grant in order to allow time for the organization to get on its feet financially: "but they wanted to support us, they (the VRA) saw their role as capacity building" (Participant 2).

In speaking about the financial structure of CARF in 1976, Alan Toppel said:

"Our major source of income is derived from the fees paid for site surveys...[however] our experience to date is that the Commission is still not recapturing the total costs in this area. But due to the level of commitment of our sponsoring organizations, we have continued to receive their financial support. Together with federal grants and foundation support for some specific activities, we have continued to maintain the Commission in a fiscally sound position" (Toppel, 1976, p. 21).

Over time, CARF also began to print and sell copies of the standards manuals, which also added a further source of income for the organization.

In the early years, when CARF was still under the administrative leadership of the Joint Commission (JCAH), the survey fee was calculated as a percentage of the annual budget of the facility undergoing the survey. However in the mid-70s, according to a CARF staff member at the time: "We looked at it (the survey fees) after a while and began to say – what does that have to do with what it costs to do a survey" (Participant 2)? Therefore around that time the survey fees became more standardized, and reflective of the actual costs of conducting a survey. During the 1970s, the average survey fee for a facility was set around \$400 (Participant 2).

During the late 1970s, CARF moved its head office from Chicago, Illinois to Tucson, Arizona. After having split off from the Joint Commission (JCAH), as described by a previous staff member: "basically all we

needed was to be someplace where there was a telephone and an airport” (Participant 2). For a variety of personal reasons, the core staff members of CARF were interested in moving to Tucson; therefore the Board of Trustees approved the move at their meeting in December 1977 (Participant 2).

Another aspect of CARF's operations that evolved during this period of time relates to the individuals conducting the surveys. During the early 1970s, CARF changed its system from full-time employed accreditation surveyors to a peer review system. According to an interview participant, at the end of 1970 the full-time CARF surveyor decided to leave the organization, and upon reflection:

“The more we looked at the depth of the field, we decided...we need a system where people who have some specialized knowledge in that particular constituency go in and do the surveys, and apply the standards. So we came up with the independent contractor kind of relation, where people who had other primary responsibilities in the field, directing their own programs, would be able to do the surveys” (Participant 2).

As described by Alan Toppel (1976, p. 21): “we have chosen to use individuals on the survey team that are from other accredited rehabilitation facilities...they receive only a small honorarium”.

Yet even with the small honorarium paid to surveyors, the administrative and travel costs related to a survey still put a strain on the organization in these early years, and CARF looked at the option of cutting back from a survey team (of 2+ surveyors), to a single surveyor. However according to a staff member at the time: “we got feedback from surveyors that said no, if you go out by yourself there's no one else to balance what you're thinking, it's all what you're seeing and what you're thinking. So we elected not to do that” (Participant 2). This system of peer-review surveyor teams still exists to this day.

As further described below, under the leadership of Alan Toppel the scope of the accreditation program expanded significantly, which

created a pressure to recruit and train surveyors that were connected to these various fields. According to an early staff member:

The original training program was, for the person [new surveyor] to go out and follow a survey with one of the experienced team members. Then we developed a simulation game, where we would take out all of the documents for say a vocational organization, and Alan [Toppel] would play the CEO and I would play the radio reporter, and I would have multiple roles and Alan would have multiple roles in the survey. And that's how we would train people" (Participant 2).

The training program continued to evolve over time, and in 1989, in response the heightened growth in the late 80s, CARF underwent a more intensive review to expand the training and continuing education program for surveyors, as well as training programs for agencies involved or interested in accreditation.

In terms of staff, in the early 1970s CARF operated with only a handful of employees. By the mid- to late-70s, the organization had approximately nine full-time staff (Participant 2). The staff numbers continued to grow into the 80s, as new program areas for standards were developed, and the number of agencies seeking accreditation grew. By that time there were separate 'Program Directors' for different program areas of accreditation. Overall however, as described by an interviewee: "the Alan Toppel era...he had a lot of family members working in the organization, it was kind of a family thing, and small at the time – everybody knew everybody" (Participant 6).

Standards & Accreditation

As mentioned above, the initial CARF standards were a combination of the standards developed by the Association of Rehabilitation Centers (ARC) and the National Association of Sheltered Workshops and Homebound Programs (NASWHP) earlier in the 1960s. These preliminary standards were first applied in 1968, whereby CARF "did

the initial four surveys where they kind of tried out a tentative set of standards" (Participant 2).

Alan Toppel, the Program Director turned Executive Director of CARF from 1969-1993, explained the standards development process as follows:

"Advice, counsel, and specific recommendations for changes are sought from special national advisory committees convened by the Commission [CARF], as well as from public and private sectors, providers, consumers, purchasers of rehabilitation services, and national organizations before any final action is taken" (Toppel, 1976, p. 20).

During the 1970s, according to Toppel (1976, p. 20), the national advisory committees—which are not associated with the Board of Trustees—were convened annually, and would generally focus on a different area of the standards each year, and thus involved different groups of people. As the scope of CARF's work grew over time into the late 70s and 80s, national advisory committees were organized sometimes more frequently based on need, however the general practice for developing standards remained the same. The recommendations of the national advisory committees, as well as various related working groups, would be presented to the standards committee of the CARF Board of Trustees, who would "work on the standards, and then at the full Board meetings they (the standards committee) would present their recommendations" to be ratified (Participant 3).

Criteria of eligibility for CARF accreditation

- "Must be one of four types of programs: 1) physical restoration, 2) social adjustment, 3) vocational adjustment, 4) sheltered remunerative employment;
- Must operate without limitation by reason of race, color or national origin;
- Must operate under a legally constituted governing body;
- Must have operated for one year, Must have appropriate ancillary services available, must have an annual professional review of employable clients in a sheltered workshop, must have certain requirements depending on the type of facility regarding full-time professional staff, and must have administration vested in a chief executive"
- Plant and equipment must be used exclusively by rehabilitation facilities' program and under their control"

Figure 4: Criteria of Eligibility for CARF Accreditation (Bowman, 1970, p. 42-46)

The accreditation process began with an assessment of whether a facility met the eligibility criteria for CARF accreditation (Criteria in 1970 listed in Figure 4). One major change in the criteria that occurred in the early years is the removal of the requirement that a facility must be a nonprofit organization. This was amended in March 1969 “to include facilities that meet all of the other CARF requirements even though they are proprietary facilities” (Bowman, 1970, p. 45).

Once it was determined that a facility was eligible, and the facility underwent the necessary preparations, the surveyor would visit the facility to carry out the field review process and prepare a report. The report would then go to the CARF office and “undergo a thorough review by the CARF field staff and the field research team. When the report passed the office review, it was reviewed by the CARF board of trustees [and later the accreditation committee] by mail ballot and had to be passed unanimously by the members or it would be held over until the first regular board meeting where a majority vote would decide a course of action” (Bowman, 1970, p. 46).¹

The accreditation process underwent a significant review in 1970, which resulted in changes to the accreditation process and helped to shape the overall values and objectives of the organization. According to an interview participant: “Some of the key decisions were around the subject of, what's our basic purpose, I mean – are we in business to put a stamp of accreditation, to make go, no-go decisions, to make summative evaluations, or was our purpose to be more causing the improvement of services to people with impairments” (Participant 2).

The review involved a critical look at the initial surveys conducted in 1968-69, and specifically followed up with organizations that had not

¹ *For a detailed account of the accreditation process see Bowman, 1970, p. 44-48

been successful in meeting the accreditation standards. As described by a staff member at the time:

We looked at what happened within those organizations, in terms of making improvements that had been identified by the surveyors. And the ones that had been not accredited, there was absolutely nothing that had been done. We tried to figure out why, and the reason was that if they began to try and do something that the surveyors had suggested, that would suggest that the surveyors were right...they were in a defensive mode, trying to say no, the surveyors were wrong" (Participant 2).

Upon reflection, CARF decided to introduce a 'twelve month abeyance', whereby if a facility did not meet the standards during the initial survey, CARF would give them up to one year to correct the problems, and then the surveyor would return and reassess the facility. This approach significantly increased the success rate, with the majority of facilities that were granted an abeyance able to meet the requirements and achieve a full 3-year accreditation (Participant 2). This review solidified the guiding purpose of CARF for staff at the time: "If our basic purpose was to make improvements in the delivery of services to people with disabilities, the tool to do that was the accreditation process. The purpose was not the making of the accreditation decision, the purpose was to cause improvement" (Participant 2).

Another change to the accreditation program that came about later in the Alan Toppel era was the development of a six-month preliminary accreditation, for newly opening facilities. This was in response to an increase in state mandates for accreditation, which required accreditation for facilities to be eligible for state funding. As this initially created a barrier for new facilities to open, the six-month preliminary accreditation was based on the meeting of certain parameters prior to opening, whereby a full survey would then be conducted at the end of the six months (Participant 2).

New areas of standards – Responding to demand and opportunities

The first major milestone in CARF's accreditation program was the move towards developing standards for program evaluation. As described by a former CARF staff member, in the mid-1970s:

"We convened our first national conference and it was entitled 'Rehabilitation and the Measurement of its Results'. There we asked people—and these were leaders in the industry—we asked the people, what was the tool, what mechanism might exist that could facilitate the field getting more into outcome evaluation. And they came up with the recommendation that CARF take the leadership role in the industry for causing a movement towards getting results. And from there we started going down the road...and we focused around – if you're going to have a [program] evaluation system, it should meet certain standards of quality itself" (Participant 2).

In November 1973 CARF began this process by publishing a new section of the standards manual, specifically focused on program evaluation. In 1977, CARF utilized these preliminary standards to set up their own system of program evaluation, in order to provide ongoing assessment of their effectiveness as an organization.

In the late 1970s and early 80s, CARF moved to expand and strengthen its standards for program evaluation. This was also partially in response to a new law enacted in 1975 by the Federal Department of Health and Human Service (Public Law 94-103) that "required states to mandate that agencies install evaluation systems" with a specific focus on outcomes measurement (Carter, 1983, p. 56). CARF formed a national advisory committee on program evaluation, which included representatives from private research firms, rehabilitation associations, and the federal government, in order to develop standards for program evaluation that matched the federal requirements.

CARF subsequently hired an agency from Minneapolis called Walker and Associates to manage the project. The project was lead by Robert Walker, who had been a member of the national advisory council on program evaluation, and was described as: "somebody way ahead of

his time in terms of looking at outcomes and results, not from the standpoint of full-blown research projects...but from an operations research standpoint” (Participant 2). CARF was able to procure grants from the Kellogg Foundation and the Eli Lilly Foundation in order to fund this initiative, which produced a “client-outcome monitoring systems” for 130 agencies (Carter, 1983, p. 56), as well as three publications that came out in 1982, to act as resources for agencies/facilities: “‘Program Evaluation – A First Step’, ‘Program Evaluation for Medical Facilities’, and ‘Program Evaluation for Vocational Facilities’ (Participant 2). Guidelines specific to other types of service providers, such as speech and hearing rehabilitation, were published soon thereafter.

By the 1980s, CARF had begun to develop standards in several new, and/or more specific areas of rehabilitation. In 1982, CARF released their first standards manual for psychosocial rehabilitation programs, and in 1983, CARF began to accredit chronic pain programs. In 1986 standards for two new program areas were published – respite programs for people with disabilities, as well as alcoholism and drug abuse treatment programs. By 1988, standards also emerged for post-acute brain injury programs as well as community mental health programs.

The development of these new areas of standards was often initiated by provider or professional associations—usually sponsoring members of CARF's Board of Trustees—who would approach CARF to develop standards specific to the needs of their membership. As described by a previous employee:

“By that time, the mid-80s, facilities organizations were coming to CARF to ask us to develop standards. Like the NAATP (National Association of Addiction Treatment Providers) - they came to us and said we really need to have standards for our constituency (approx. 1982). We don't like the medical model and what's out there right now is the Joint Commission. We need something that reflects our ideology” (Participant 2).

This tension between the ‘medical model’ as opposed to the ‘support model’ (or ‘recovery’) was described as a key point of division in the

process of developing standards, specifically around program evaluation. In the case of behavioral health programs for substance use:

"The key issues for them, and the division point was, for example...is the way you evaluate a program based on whether or not it has caused people to stop drinking (or using substances), period? Or, the other part of the constituency would say no, we're looking from a recovery model, and that could be incremental in terms of people stopping drinking or using substances" (Participant 2).

These are the types of debates that would play out on the advisory committees and within the Board of Trustees, in the development of the CARF standards.

In general CARF funded the development of these new areas of standards: "the advisory groups—from field review to the writing—was considered to be a cost of doing business in the CARF world" (Participant 6). As explained by the interview participants, the development and maintenance of standards was considered an appropriate use of the survey fees, as well as part of what the sponsoring organizations were paying for (Participant 2).

Overall, according to another interview participant associated with the organization in the 1980s: "CARF was always open to adding new areas...I think the approach was to keep the door open wide, and to keep adding programs and services" (Participant 3).

Growth

In conjunction with expanding the breadth of standards for different types of programs, CARF also pursued opportunities to deepen the reach of CARF accreditation within each of the various program areas. During this early developmental period of CARF's operations the majority of accredited programs were located in the United States, although CARF did begin accrediting some programs in Canada as early as 1969.

As explained by a former CARF employee, the organization realized early on that for private accreditation to be successful, some type of

mechanism would be necessary to create incentives and consequences around the accreditation process (Participant 2).

"The problem is that Alan and I would go out and we'd do a dog and pony show, and we would have people come up and say – we're right around the corner, we really want to do this, and I just have to convince my Board, is there something that we can do with this that we can't do without it? And absent any incentives or consequences, aside from the achievement of good quality services, it wasn't going to be sufficient" (Participant 2).

Thus began a focus for CARF—primarily in the U.S. at the time—to connect with public agencies and get them to recognize CARF accreditation, and implement a mandate for accreditation into their funding policies.

Although there were aspects of federal legislation that did impact the 'market' for accreditation during this time period—such as the *Social Security Act* amendments in the early 1970s, and the Medicaid waiver program in the early 1980s—CARF did not invest a lot of resources into lobbying at the level of the Federal government, and were not involved in developing any kind of legislation initiatives (Participant 2). Instead the major focus during the 1970s and 80s was at the state level. The Executive Director of CARF Alan Toppel, as well as other senior staff at CARF, would go to speak at meetings for public agencies, annual meetings of facilities, and they were also involved with the Council of State Administrators of Vocational Rehabilitation (CSAVR), the association representing state vocational rehabilitation Directors in the United States (Participant 2).

As described by Terry Etling, who was a member of the CSAVR and subsequently became a Trustee for CARF in the 1980s, "they (CARF leadership) were active with the CSAVR, they would come in when CSAVR met and they would participate" (personal communication, October 24, 2014). Through this relationship, the CSAVR passed a recommendation in 1971 that "urged state agencies to work towards the goal of having all organizations that provide rehabilitation services accredited by CARF" (Brommel, 2006, p. 49). However as described by Etling, this was mostly symbolic, as a recommendation instead of a

mandate, “it was then CARF’s job to go to the states and convince them that they should get on board with a mandate” (personal communication, October 24, 2014).

In order to achieve this objective, the strategy was two-part, as CARF had to achieve support from both the state representatives as well as the constituencies to be affected by the mandate. Thus the first step was to make connections with individuals within the state agency, who would be “willing to go to bat for putting a mandate in”; and the second step was to “get the facilities organizations and some key people within that constituency to say to the state – we want you to do this” (Participant 2). As explained by an interview participant, “most states would not initiate something as decisive as a mandate without the organizations that would be affected, in some organized voice, saying yes we want this” (Participant 2).

In terms of building this network, the CARF management and employees, Board Members, and surveyors would reach out to ‘opinion leaders’—i.e. influential actors—within the different constituencies. As well, CARF would actively recruited such opinion leaders from both state agencies and provider organizations to become involved with CARF – as surveyors, participants in advisory committees, or membership on the Board of Trustees.

In regards to reaching out to the state agencies, Terry Etling, who was the Director of Program Support with the Ohio Rehabilitation Services Commission, and was later asked to serve as an at-large member of CARF’s Board of Trustees in the 1980s, states:

“Some of the state vocational rehab agencies operated state-based facilities, particularly in the South, like Virginia, West Virginia, and North Carolina. I was able to work with the state VR people in those states, for example, we had a conference where we brought in the Director of the South Carolina agency, and some of the senior staff, with CARF...and as a result of that input and joint development we were able to get...all of the state-operated rehab facilities on board with the CARF mandate. It was an

ongoing process of making sure that they had input, and that they bought into the standards. Their comfort level talking to another bureaucrat like me was better than talking exclusively to somebody representing CARF" (personal communication, October 24, 2014).

Overall Etling describes a lot of communication and resource sharing between the states during this period of time, through the structure of the CSAVR and otherwise, and thus by achieving mandates within several key states CARF accreditation mandates began to spread.

CARF also pursued opportunities to gain stature and exposure politically for the organization. In 1976 CARF celebrated its 10-year anniversary and received a congratulatory letter from President Ford, and in 1979 received recognition from President Carter for its work with disabilities. Then in 1981, President Reagan congratulated CARF for its 15-year anniversary, and described the organization as a "national example of the private sector meeting public needs". According to a previous staff member, "we needed to get exposure and credibility so we aggressively pursued, and then gave wide exposure to the Presidential recognition. It was not common at all, Alan Toppel played a major role in networking to get them" (Participant 2).

At the same time, CARF was actively networking with providers and communities within the various state constituencies, in order to build support from those who would be affected by the state mandates. This was achieved in large part through the sponsoring member organizations of the Board of Trustees. CARF established quite strong relationships with some of the initial sponsoring member organizations such as Goodwill Industries and the National Easter Seals Society. In 1969, the Indianapolis Goodwill became the first Goodwill in the United States to become accredited by CARF, under the leadership of then CARF Board member Howard Lytle.

Several national associations that had approached CARF to develop standards for their members—including the American Spinal

Injury Association (ASIA), the National Association of Addictions Treatment Providers (NAATP) and the National Head Injury Foundation—took positions to encourage their members to become accredited (Participant 2). In terms of funding incentives, the Association of Trial Lawyers of America adopted a resolution in 1980 urging state workers' compensation agencies to require CARF accreditation for rehabilitation organizations serving workers with occupational disabilities, and United Way of America also took a position in 1983 to encourage local United Way organizations to consider CARF accreditation when making program funding decisions (Brommel, 2006, p. 50). However it was the (U.S.) National Easter Seals Society that took the strongest position, as it eventually adopted a mandate in the 1980s that required all local Easter Seals programs affiliated with the National body to be accredited by CARF.

Aside from providing incentives and consequences, state mandates were also vital to the uptake of CARF accreditation as generally the state would fund the cost of the accreditation process: “Most of the states that did subsequently mandate, they did put in funding to pay for the initial round of CARF accreditation surveys for those organizations so they wouldn't have to foot that bill themselves, and then they could just build it in to the organization's contract with the state, just built it into their operating costs” (Participant 2). Although there were administrative and program related costs associated with implementing the standards, this funding did help decrease the barriers for service providers.

Lastly, in the mid-80s, CARF began a “big push” to move into the area of behavioral health and developmental disability services, and thus hired an experienced man in the field named Barry Carson, who “put CARF on the map in doing that” (Participant 2).

Mandates

The first state to implement a mandate for CARF accreditation was Washington in the late 1970s. Prior to the mandate the state had its own process of review, whereby a state agency would conduct evaluations and certify organizations. However as described by an interview participant, a new Director came into the Division of Vocational Rehabilitation, and found that the state review process “didn’t have a whole lot of credibility because it was mired in politics with a capital P” (Participant 2). Therefore by mandating CARF accreditation he “got some heat, but it gave him some insulation” (Participant 2).

The second state to mandate was Ohio, and the third was California. Both of these mandates were for vocational rehabilitation providers. As explained by an interview participant: “most mandates at that time came on the Joint Commission (JCAH) side for medical rehabilitation” (Participant 2). The Ohio mandate included a few other accreditation options, including the National Accreditation Council (NAC) and the American Speech-Language-Hearing Association (Etling, 1976, p. 21).

By the mid-80s, approximately a dozen states had mandates for CARF accreditation, specifically for vocational rehabilitation services, according to a CARF employee at the time (Participant 2). The state of Colorado implemented a mandate around that time, also for employment services that were funded by the Division of Vocational Rehabilitation. At that time CARF was the only recognized accreditation body (Participant 4).

Example: Ohio Mandate

“In Ohio, we had developed our own set of standards. At that time I was the head of the Facilities Division within the state agency, and I was the one who decided that on balance, even though the standards that we had developed were okay, I thought that going forward we were going to be better off if we participate in a national program...Most state voc. rehab agencies were pretty small organizations, and I didn't think we could compete with a full-time organization that was in business to apply standards and keep them current, and to assess and act on feedback from the people in the facilities that were being accredited.

I also thought it was going to be a lot more economical in the long run to have a national organization who's fulltime business was accreditation, whereas for us it would be just one more assignment. And I also felt it would be greater credibility if we had an organization like CARF, who's full time business was accreditation, if they came in and applied the standards. Versus having people who worked for me, who were known as facilities specialists...their job was to be consultants to the facilities that we bought services from. I thought that it would be better if they didn't have to wear two hats. One, where they were coming in and applying the standards, the other where they were consultants to the facilities, where they could provide grants and technical assistance, and other resources to the facilities that were providing services for us to improve.

The fourth reason I think was that having a third-party and a peer coming in and applying the standards, versus a representative from the state agency, would go over better and have more credibility with the providers, than us developing the standards and then applying them. So for that reason, and I think it was somewhere around 1974, we mandated that CARF and I think there was also the National Accreditation Council...we kept that mandate in place into the 80s.

When we made the decision to mandate CARF, we also decided that we would provide, a year or a year and a half for people to get on board, and we provided technical assistance. We paid to have people come in from CARF to help the facilities in Ohio get ready for the mandate, and do some training in terms of – these are what the standards are, and this is what the survey process is like, and over that time, from the time we announced the mandate, we provided a lot of help to get the facilities ready so they didn't feel like we were just putting a mandate on them and not helping” (T. Etling, personal communication, October, 24, 2014).

Figure 5: Example of State Mandate - Ohio

PHASE 2: Building the market (1990s)

Context

In a Special Report by (then) CARF Executive Director Dr. Donald Galvin (1999, p. 5), he describes the “social, economic and political dynamics” that impact accrediting bodies and their standards. Along with public policy and legislative measures specific to the various program areas served by CARF, Galvin (1999, p. 5) identifies the “consumer movement with special reference to disability rights”, as well as the “profound influence of the purchaser of health and rehabilitation

services". The disability rights movement is rooted in the *Americans with Disabilities Act (1990)*, which established protections against discrimination and requires reasonable accommodations from employers. Further, the 'consumer movement' as described by Galvin (1999, p. 5-6) pushes for greater participation and decision-making power for consumers to determine the services they receive.

In terms of the influence of the purchaser, Galvin (1999, p. 6) states: "As a society, we have reaffirmed our belief that product and service quality is best enhanced through competition and attention to customer satisfaction", whereby "survival in such a marketplace depends on organization's ability to know its customers, its processes, its costs, and its outcomes". In this way Galvin identifies an increasing pressure on service providers to utilize data and information systems to maximize quality improvement, efficiency, and consumer satisfaction. Overall, Galvin describes accreditation bodies as "derivatives of the field or industry that they are to monitor" (1999, p. 6).

During the 1990s, the Medicaid waiver program continued to shift rehabilitation services into community and home-based settings—creating a larger market for private accreditation (Participant 6). This was further propelled through case law, such as the U.S. Supreme Court decision in 1999 (*Olmstead v. LC*), which favored home- and community-based services over institutional assisted living for people with disabilities.

In terms of vocational rehabilitation, a major shift in policy that began in the late 80s generated a significant impact on this sector across the 90s and beyond. In 1986, Madeleine Will, the Assistant Secretary for the Office of Special Education and Rehabilitation Services (U.S. Department of Education), proposed the 'Regular Education Initiative' in an annual report on special education, which challenged the segregated approach to serving people with disabilities. She (Madeleine Will)

simultaneously ran a demonstration project that legitimized this new approach and as described by an interview participant, “Madeleine Will came in and turned over the truck” (Participant 6).

Prior to this, vocational rehabilitation services were almost exclusively delivered through a segregated system of sheltered workshop. The new philosophy of supported employment took the approach: “we can actually go in and identify a job and provide the training and supports on the job, and people can go right to work in their community” (Participant 6). In 1986, the *American Rehabilitation Act Amendments* identified ‘supported employment’ as a ‘legitimate rehabilitation outcome’, and in 1986 and 1989, the first major grants came out from the Federal Rehabilitation Services Administration to support this new approach, which initiated a “major upheaval in the American Employment System” (Participant 6).

During the 1990s several different aspects of U.S. federal regulation around standards and quality control underwent reassessment, which helped to generate a market for private standards and accreditation, in new areas for CARF. First, in terms of behavioral health, in 1990 the U.S. General Accounting Office (GAO) released a report suggesting that “existing FDA regulations for methadone programs did not ensure quality treatment...and recommended that results-oriented performance standards be developed” (Pelletier, 2001, p. 2).

Second, beginning in 1989 veterans’ services in the United States began a significant transformation process that spanned the subsequent decade. In that year the Veterans Administration achieved Cabinet status and became its own Federal Department. Concurrently, the Veterans Health Administration (VHA) began what it called a “Journey of Change’ to transform the way the Administration delivered care, and respond to

“increased demands for accountability...demonstrable effectiveness and greater efficiency” (Veterans Health Administration, 1997, p. 1).

Third, there were also changes to government policy in the United States within the realm of nursing homes and assisted living—both of which primarily serve the elderly, but also some mental health and disability clients. Both nursing homes and assisted living facilities are regulated at the state level, however the federal government is a significant funder through the Medicaid program, and thus does dictate the conditions of that funding.

In 1987 the *Federal Nursing Home Reform Act* (part of OBRA '87) was passed, as the first major revision to nursing home standards since the creation of Medicare and Medicaid in 1965. These reforms increased the quality of care requirements as well as the monitoring and enforcement policies by the Federal government, for nursing home facilities receiving Medicaid funding (Turnham, 1987). Similar to the impact of the Medicaid Waiver program in the 1980s, this move put extra pressure on states as well as service providers to look for quality monitoring mechanisms, such as accreditation.

In regards to assisted living, in the late 1990s the Federal General Accountability Office (GAO) published a report that reviewed assisted living providers and practices in four U.S. states, as requested by the Senate Special Committee on Aging. The report brought forward a number of concerns, and identified quality of care as an issue that was not adequately being addressed by the existing state inspections and surveying practices (United States General Accounting Office, April 1999). This report incited a national discussion around how to regulate the assisted living sector.

In January 2001, the Institute of Medicine (IOM)—the health-focused research section of the U.S. National Academy of Sciences—released a

report on quality improvement in long-term care for seniors stating “any modifications to the state regulatory system for assisted living “need not mirror the extensive federal regulatory oversight that is in place for nursing homes” (Institute of Medicine, 2001b). Also in January 2001, The (U.S. Federal) Health Care Financing Administration (*now Centers for Medicare & Medicaid Services) issued a new protocol for assessing the quality of care provided to assisted living residents who receive funding through a Medicaid waiver. The protocol required the Federal Administration to evaluate each state's quality assurance systems. Overall these events opened a market for private accreditation in the assisted living sector.

Another change that occurred over the 90s was an increase in competition between accreditation bodies. While in the late 1990s, Goodwill Industries International stopped its accreditation program, there was also a “proliferation and growth of accrediting organizations” (Edmunds et al., 1997, p. 214). During the late 80s and 90s, as explained by Edmunds et al. (1997, p. 214) – new accreditation organizations form as new demands or priorities emerged in terms of quality assurance and oversight. For example, the National Committee for Quality Assurance (NCQA) was founded in 1990, with standards focused more on administration of health care systems (or ‘networks’) as opposed to specific programs, which had become an important topic in the industry at that time.

Alongside CARF, other accrediting bodies such as the Joint Commission (JCAH) and the Council on Accreditation (COA) (est. 1977) were continuously moving into the same newly emerging markets for accreditation. As an example, with the emerging market in the assisted living sector in the late 1990s and early 2000s, the Joint Commission (JCAH) began a new surveying and accreditation program for assisted living in

the year 2000, which CARF also did in the same year. Even within existing markets, competition became more significant. In 1993, CARF sent a 'cease and desist' letter to the American Academy of Pain Management—a competing industry association to the American Academy of Pain Medicine, a CARF sponsoring member organization—for their use of accreditation materials similar to CARF's. Overall, as compared to the previous period of CARF's operations, the competitive nature of the industry created pressure for more strategic and protective behavior on apart of the different accrediting bodies.

Leadership & Governance

In 1993, Dr. Donald Galvin took over as the Executive Director of CARF. As described by an interview participant “with the growth that began in the late 80s, the sophistication and rapid expansion kind of called for a change, so there was a change to Dr. Don Galvin; he came in as a very strong bright academic kind of angle” (Participant 6). Dr. Galvin is described as having a strong focus on research, education, and training (Participant 6), which is exemplified by his involvement in numerous research and policy development opportunities during his time at CARF. In 1993 he contributed to the development of a background paper on the Americans with Disabilities Act, published by the U.S. Congress Office of Technology Assessment (in March 1994). In 1997 he participated in a committee organized by the Institute of Medicine (IOM) on managed behavioral health care.

Across the 1990s, the CARF Board of Trustees continued to grow: from 36 Trustees in 1989 (18 from sponsoring organizations; 18 at-large), to 45 Trustees in 1995 (25 from sponsoring organizations; 20 at-large), to 47 members in 2000 (34 from sponsoring organizations; 13 at-large). The representatives appointed by sponsoring organizations were either

elected or appointed by their organization (Participant 5). The Board of Trustees elected the at-large members. As described by an at-large member from the 1990s: “the application process was very different, we had to be selected because we had something to contribute” (Participant 4).

The Board committees were also still in operation during this period, with seven committees identified in the Annual Report filed in April 2000: Executive Committee; Accreditation Committee; Finance Committee; Governance Design Committee; Nominating Committee; Planning Committee; Standards Committee; Survey Procedures Committee.

In the year 2000 CARF also had a component of 21 Associate Member organizations, which made a smaller contribution to the organization and did not appoint representatives to the Board of Trustees.

Similarly to the previous era of CARF under the leadership of Alan Toppel, there was a lot of communication and collaboration between staff and Trustees under the leadership of Dr. Galvin: “he was very open to everyone going to Board meetings and connecting with Board members, that sort of thing” (Participant 6).

Evolution of the Board of Trustees (select dates)

1990:

- 18 At-large Member; 18 Sponsoring Member Appointees
- **Sponsoring Member Organizations** (1 member each)
 - *American Academy of Neurology*
 - *American Academy of Orthotists and Prosthetists*
 - *American Academy of Physical Medicine and Rehabilitation*
 - *American Hospital Association*
 - *American Occupational Therapy Association*
 - *American Physical Therapy Association*
 - *American Psychological Association*
 - *American Speech-Language-Hearing Association*
 - *Association of Rehabilitation Nurses*
 - *Federation of American Health Systems*
 - *Goodwill Industries of America*
 - *Intl. Association of Psychosocial Rehabilitation*
 - *National Association of Addictions Treatment Providers*
 - *National Association of Jewish Vocational Services*
 - *National Association of Private Residential Resources*
 - *National Association of Rehabilitation Facilities*
 - *National Easter Seal Society*
 - *United Cerebral Palsy Associations*

1997:

- 18 At-large Members; 26 Sponsoring Member Appointees
- **Sponsoring Member Organizations** (1 member each)
 - *American Academy of Neurology*
 - *American Academy of Orthopedic Surgeons*
 - *American Academy of Orthotists & Prosthetists*
 - *American Academy of Pain Medicine*
 - *American Academy of Physical Medicine and Rehabilitation*
 - *American Hospital Association*
 - *American Network of Community Options & Resources*
 - *American Occupational Therapy Association*
 - *American Physical Therapy Association*
 - *American Pain Society*
 - *American Psychological Association*
 - *American Rehabilitation Association*
 - *American Speech-Language-Hearing Association*
 - *American Spinal Injury Association*
 - *American Therapeutic Recreation Association*
 - *Association of Rehabilitation Nurses*
 - *Brain Injury Association*
 - *Department of Veterans Affairs*
 - *Federation of American Health Systems*
 - *Goodwill Industries of America*
 - *Intl. Association of Psychosocial Rehabilitation Services*
 - *National Association of Alcoholism and Drug Abuse Counselors*
 - *National Council for Community Behavioral Healthcare*
 - *International Association of Jewish Vocational Services*
 - *Paralyzed Veterans of America*
 - *United Cerebral Palsy Associations*

Figure 6: CARF Board of Trustees 1990-2000

Operations & business practices

This era of operations for CARF began with somewhat of an overhaul for CARF, which also coincided with further changes in

management and the accreditation programs, as described below. When Dr. Galvin took over in the leadership role in 1993, as explained by a previous employee, he had a vision of starting afresh, whereby the CARF office was cleared out, and the majority of the historic files and documentation as well as the established administrative systems were disposed of (Participant 2). Within this first year, Dr. Galvin also organized the dissolution of CARF as a registered corporation in the State of Illinois, in order to re-incorporate the organization in the State of Arizona, where the main office had now been based for over a decade. Further, during the 90s CARF managed to build and move into a new head

Purposes of CARF (1994)

- 1) "To promote and assist in the self-improvement of rehabilitation facilities through the provision of education and advisory services with respect to standards.
- 2) To adopt and apply the initial standards approved by the original members in measuring and evaluating rehabilitation facilities for accreditation with respect to: organization, types and quality of services, personnel, records and reports, fiscal management, physical plant, the efficiency of industrial activities when provided and such other factors as may be deemed consistent with the goals of the facilities to be accredited.
- 3) To seek advice and guidance from all appropriate sources in regularly reviewing and reevaluating standards and to promote and carry out studies for the purpose of expanding and elevating.
- 4) To cooperate with other organizations having similar or allied objectives and to take into membership such other organizations upon terms and conditions as may be mutually desirable.
- 5) To assume such other responsibilities and to conduct such other activities as are consistent with the administration of a program of educational and advisory services and a program of accreditation of facilities.
- 6) To carry out such programs in the United States of America, Canada and in such other countries as may be appropriate and feasible".

Figure 7: Purposes of CARF (Articles of Incorporation, 1994)

office building.

In 1994, Dr. Galvin rearranged the structure of the organization into three divisions: Vocational and Employment / Developmental Disabilities; Medical Rehabilitation; and Alcohol and Other Drugs / Mental Health. At

this time, CARF convened a National Leadership Panel for each of the three fields, to assist in identifying key issues and trends and contribute to strategic planning.

A similar business structure still remains in place today, however during this period of time, the segmentation of the different divisions began to pose certain challenges, as larger multi-dimensional organizations with multiple funding sources and regulatory mandates began to seek CARF accreditation.

As described by an employee at the time: “ The discussions internally (within CARF) became troublesome initially when a large organization was getting funding for medical, unemployment, the Medicaid waiver, behavioral health, a retirement program...for one the question was – what department would they go under?” (Participant 6). More so this type of scenario would also elicit tensions based on the philosophical differences between the different programs—i.e. the medical treatment philosophy as opposed to the community supports ('recovery model') philosophy.

By the 1990s CARF had also become fully self-sufficient in terms of the financial structure, whereby the primary source of income was the survey fees, which generated enough revenue to cover the operating costs in a sustainable way. Although the Sponsoring Member Organizations still contributed financially to CARF, the sponsorship fee remained at \$5000 and thus by the 1990s this income was not a significant portion of the revenue. The total net worth of the organization grew significantly over this period of time. Beginning in 1994 with a net worth of just under \$2million, CARF grew steadily to be valued at over \$8million in the year 2000. However as described by a previous CARF Board member: “CARF has a very big budget, but if you delve into that budget, a very large percentage is basically money in, money out, for the travel

expenses of the survey teams. The actual operations are not nearly as large a percentage as you would think (Participant 4).

Standards and accreditation

During this period, the process for developing and revising the standards remained similar to the previous era, whereby committees and working groups were formed to produce or revise the standards—a process organized and facilitated by the CARF staff—and then the Board's Standards Committee would review and approve the standards. In conjunction with restructuring the organization into three separate divisions, CARF also changed its standards manual publications. Prior to the restructuring all of the standards had been issued under a single standards manual for rehabilitation facilities, then after 1995 CARF began to issue separate editions for each of the main areas of accreditation: Employment & Community Services, Medical Rehabilitation, and Behavioral Health (Brommel, 2006, p. 50-51).

Under Dr. Galvin's tenure, CARF standards and accreditation expanded significantly, including major changes to program areas and standards that had already been established, as well as moving "into areas not traditionally identified with rehabilitation" (Brad Contento, personal communication, October 16, 2014). While all of the standards were frequently reviewed and updated, one of the more significant changes occurred in the vocational rehabilitation program area: "the methodology now for vocational rehabilitation, both state and federal, is that they will not go to these sheltered workshops, they will go into the workforce with supports and services" (Participant 6). With this major policy shift incited by Madeleine Will that began in the late 1980s, CARF brought in a new Program Director, Mr. Paul Andrew, who had recently directed a three-year supported employment pilot project in the State of

California (Participant 6), to help update the standards in this area to suit the new approach to program delivery.

One aspect of the standards that changed significantly during the 1990s was the approach to program evaluation. As described by a former staff member, “Don Galvin and the Research & Education Director (at the time) were much more interested in peer-research, and much more moved by peer research than before, where we had more of an operational focus (under Alan Toppel)” (Participant 2). When Dr. Galvin took over in 1993, there was also significant feedback from service providers, especially in the employment and community services sector, that the existing approach to program evaluation was too elaborate and time consuming, and was not really contributed to the improvement of services (Participant 6).

This pushback was further supported by the new approach promoted by Madeleine Will, who advocated for a policy and funding focus solely on outcomes instead of processes/practices (Participant 6). In response, in the early 1990s the program evaluation standards were drastically reduced, “with a great deal of flexibility inserted” (Participant 4). Although the program evaluation standards became stricter again in 1998 following a survey, this area of the standards continued to be worked on throughout this decade in search of the right balance in approach.

In the late 1990s CARF also developed an array of new standards and program areas including: adult day services; pharmacotherapy; crisis stabilization; employee assistance; children and adolescent services; and service network administration (Brommel, 2006, p. 51). The new standards for adult day services came about after one of CARF's sponsoring member organizations - the National Adult Day Services Association (NADSA) asked CARF to develop standards for, and accredit its members.

In the year 2000 CARF published a standards manual for assisted living programs. This corresponded with the above mentioned nationwide policy debate around regulation and quality assurance of assisted living providers. The CARF standards were developed through a national advisory committee that included representatives from the American Association of Retired Persons (AARP), the Older Women's League (OWL), and state regulators, amongst others.

During the late 1990s CARF also released new standards related to 'patient assessment and referral procedures', and around the same time CARF was involved in developing a new approach to patient assessment for rehabilitation facilities funded by Medicare. The Federal government then adopted this new patient assessment tool called 'MDS-PAC' as a rule for Medicare funded facilities in November 2000.

Growth

During the 1990s, CARF's accreditation programs began to grow beyond the United States. In 1996 CARF accredited its first medical rehabilitation program outside of North America, in Sweden. In 1998 CARF also began a collaborative partnership and pilot project with the Provincial Workers' Compensation Board (WCB) in Alberta, Canada. This partnership was facilitated by Dr. Brian Boon, who was at that time in a leadership role with Alberta's WCB, and who had begun his work with CARF as a surveyor in the early 90s, became an at-large member of the Board in 1998, and would soon replace Dr. Galvin as the CARF Executive Director/CEO in 2001. However during this period, CARF's business outside of the United States still remained relatively small.

The major segment of growth for CARF in the 1990s was in the employment and community services division. This was directly related to the policy shift in vocational rehabilitation that began in the late 80s, from

a sheltered workshop approach to supported employment approach to service delivery. The first major grants from the Federal Rehabilitation Services Administration came out in 1986 and 1989, and as described by an interviewee, “that enormous amount of money came with it the worry by state staff and politicians...it’s been so easy to watch over the sheltered workshops – what are we going to do with these hundreds and thousands of people now all over our community” (Participant 6)? CARF realized this was a market; they “saw this large amount of Federal money and influence going towards community employment and integrated design” (Participant 6). Therefore they brought in Mr. Andrew to lead the way into this new program area, based on his previous experience in supported employment.

In order to carve a place for CARF in this new market, Mr. Andrew utilized the network of individuals and organizations associated with CARF:

“I was doing it with the Board, doing it with my accrediting surveyors, and doing it with the people and families that we were serving and their associations. I knew from the start that in my part of the world, if I didn’t bring them all on, if I didn’t have them down at the professional hall that night, if I didn’t have them down at the state council that night to push the policy through... The point being that once they took ownership to it, and were empowered to go speak on behalf of the accrediting body, people and families and their associations, that was the methodology. That’s how it always worked for me, in this segment of the business. You had to have the help of the associations, people and families, and others to like this and want to make sure we put the policy in place with our state government. They would make the decision. What I would do simply is teaching, learning, education, networking...it was a real networking and personal relationship kind of thing that made it happen” (Participant 6).

Through such an approach, the Employment and Community Services division grew tremendously, and the number of state mandates for vocational rehabilitation service providers continued to grow. According to Mr. Andrew (personal communication, October 20, 2014), when he started with CARF in 1989 he had around 300 accredited agencies within his program area, whereas at the height of growth in this segment there were over 2400 accredited agencies.

Beyond the new market in vocational rehabilitation, CARF continued to actively push for state mandates in all the accreditation divisions, as fundamental to the maintenance and growth of the organization. In general, the CARF Board of Trustees played a huge role in advocating for mandates. As described an interview participant, “our success was rooted in having Board members for state governments, Board members from national associations working with state directors, and persons from providers who were accredited...and kind of illustrated to the decision-makers that here’s a good way to raise everyone’s quality” (Participant 6). According to a previous CARF Board member: “I was extremely active getting accreditation mandated in my State, I was involved in a number of committees, and pushed for it in my meetings with department heads, cabinet positions in the state, as well as the political gubernatorial level” (Participant 5). Oftentimes state associations would also move towards a private accreditation mandate (such as CARF) because they felt the in-state accreditation or surveying program was in a conflict of interest (Participant 6).

Another area of CARF’s accreditation business that took off in the 1990s was the contracts with Federal government departments in the United States. As described in the context of this section, the Veterans Health Administration within the Department of Veterans Affairs (VA) in the United States began a ‘Journey of Change’ in the late 1980s, and in 1990 two representatives of the Department (VA)—Dr. Leigh C. Anderson and Harry Marshall—initiated an agreement between CARF and the VA. Dr. Anderson became the first Chair of the VHA-CARF Accreditation Steering Committee, and CARF began by surveying some of the VA medical programs, and soon began surveying VA employment programs as well (CARF-International, 2005, p. 3-4). Then in January 1997, CARF signed a contract with the VA to accredit all of its rehabilitation programs. The VA

also requested CARF to develop standards for comprehensive blind rehabilitation services, which CARF then published exclusively for the VA in 1999 (these standards later became available to the private sector in 2003).

A second significant Federal contract emerged for CARF in the behavioral health sector. In response to the report issued by the U.S. General Accounting Office (GAO) that criticized the existing regulatory system for methadone programs, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded CARF and the Joint Commission (JCAH) a contract to develop and implement standards and accreditation for opioid treatment programs in the United States (Brommel, 2006, p. 51; Pelletier, 2001). This project was carried out over several years, producing \$330,000 revenue for CARF in the year 2000 (CARF, 2002). Then in 2001, the U.S. Congress released new federal regulations on methadone treatment programs, which shifted from the Food & Drug Administration's inspection model, to the SAMHSA administered accreditation model, whereby CARF was recognized by SAMHSA as an approved accreditor for opioid treatment programs. In this way, from the contract with SAMHSA, CARF grew into a recognized option under a federal government mandate for private accreditation.

Mandates

The federal mandate from SAMHSA for private accreditation was the first of two examples recognition for CARF in federal-level mandates within in the United States during the 1990s. The second example occurred within the Medicaid program, with a revision to the provisions of the *Social Security Act Amendments (1972)*. In 1972, the amendments required psychiatric facilities for individuals under 21 to be accredited by the Joint Commission (JCAH)—as the only recognized accreditation option—in

order to be eligible for Medicaid funding. In November 1991, (then) Medicaid Director Christine Nye wrote a letter to Alan Toppel stating that there was “no statutory authority under Medicaid for automatic ‘deeming’ of inpatient psychiatric facilities to meet JCAHO standards”, and that the Health Care Financing Administration (HCFA) was in the process of revisiting the regulation (Perkins, 2000, p. 45). As the JCAH was the only recognized accreditation body, this requirement was contested by numerous interest bodies (including CARF) and in November 1994 the HCFA proposed to delete this rule from the Code of Federal Regulations (CFR), and have the Centers for Medicare & Medicaid Services develop standards. Then in 1998, a new rule was established in the Code (CFR), which changed the accreditation requirements from exclusively the Joint Commission (JCAH), to include the option of accreditation by CARF, the COA (Council on Accreditation), or other comparable standards.

In regards to state-level mandates, a number of state agencies in the 1990s began to require accreditation, and recognized CARF as one of the accreditation options. This led to a growth in the number of agencies seeking CARF accreditation, however at the same time, “what happened is that one state would say yes, we want accreditation, and then another would say – we don’t want to require it anymore because we don’t want to pay for it” (Participant 5). As well, during the 1990s states began to offer ‘waivers’ for agencies that did not want to get accredited (Participant 4). Therefore while the 1990s did demonstrate an overall growth in state mandates and recognition of CARF in the United States, there was a lot of changeover.

Mandate Examples

- **1998:** State of Kentucky Cabinet for Health Services
 - Passed amended Administrative Regulations (Title 907) that requires accreditation for nursing facilities and intermediate care facilities for the mentally retarded (disability), and gives CARF or JCAH as the two recognized accreditation bodies
- **1998:** State of Maine Department of Human Services
 - Proposed a rule (98-P259) that required nursing facilities for brain injuries to be accredited by CARF (only option) to receive Medicaid BI (brain injury) coverage
- **1998:** Washington State
 - Adopted a new rules on designated standards for facilities providing level 1 pediatric trauma rehabilitation service (requires CARF accreditation)
- **November 1998:** State of Ohio
 - Proposed rules for the workers' compensation system Health Partnership Program funding. Minimum credentials for "hospital" providers includes accreditation from CARF, JCAHO, or AOA
- **December 1998:** The Illinois Department of Public Aid
 - Adopted a rule (under Title 89) that required CARF accreditation (only) to qualify for a Rehabilitation Hospital Adjustment payment

As described by one interviewee, the state of Maine brought in a mandate for CARF accreditation in the mid-1990s for community rehabilitation providers (employment support for individuals with disabilities) funded by the state. The mandate only lasted for approximately five years however, as "many agencies claimed it was too expensive...and the Bureau of Rehabilitation did not want to pick up the tab" (Participant 5). The mandate was thus altered, and providers now have the option of choosing CARF accreditation, or accreditation that is administered by the state (Employment for ME, n.d.)

Figure 8: Mandate Examples (1990s)

In the late 1990s there was also two major mandates that emerged in Canada. In 1999, in the Province of British Columbia, the Ministry of Children & Family Development as well as Community Living BC (disability services) approved a policy that required third-party accreditation for all contracted service providers with contracts of \$500,000 or over. Around that time the province issued a request for proposals, in order to determine which accreditation bodies would be recognized as accepted options (Participant 7). Both CARF and the Council on Accreditation (COA) were recognized.

Also in 1999, based on the pilot project between CARF and Alberta's Workers Compensation Board (WCB) that had begun a year prior, the Alberta WCB began to require that all contracted rehabilitation clinics must be accredited by CARF. The Alberta WCB subsidized the first round of accreditation for all the clinics that agreed to become accredited before 2001, and waived the requirement for practitioners that received less than \$10,000 annually from the WCB.

PHASE 3: Growth and expansion (2000s)

Context

This third phase of operations for CARF is characterized by further diversification in the range of its standards and accreditation areas, as well as new products and services offered by the organization. In the 2000s, CARF has expanded beyond accreditation of what are traditionally considered 'rehabilitation services', and is a self-described "accreditor of health and human services" (CARF-International, 2014a).

In the field of Community & Employment Services, after significant growth in demand for accreditation across the 1990s, more recently there has been a bit of a push back against accreditation. As described by a former CARF employee in this field, there is a desire now for more creative choices for people, and more options: "There's a lot of disagreement about how to make this policy piece responsive to people and families, and at the same time to be responsive to other stakeholders, like your funding sources, your lawsuits, your health and safety" (Participant 5). The business portion of accreditation is quite demanding and rigid, whereas "the real movement now...is that more and more people with disabilities and their families are really looking for control of their lives, and not to be

controlled by the organizations...but have the organization shaped by the participants and families within the community” (Participant 5). Therefore while accreditation in community and employment services remains common, this position appears to be more fragile, based on current trends in the field.

The trend towards more performance-based public funding—i.e. contracts based on outcomes as opposed to services provided—that took hold in the field of vocational rehabilitation in the 1990s, also became more prominent in other fields of health and human services in the United States. For example, in 2009 the Washington State Legislature passed House Bill 2106, which required the state Department of Social and Health Services to move from service-based to performance-based contracts, for services funded by the states child welfare system (Child Welfare Transformation Design Committee, 2010).

As CARF also moved more significantly into aging services at the end of the 20th century, in the United States the field continued to be fraught with controversy and challenges related to quality of care and regulation. While nursing homes and assisted living facilities are regulated at the state level, the degree of scrutiny and resources dedicated to monitoring and enforcement ranged significantly. A broad range of private accreditation and rating-systems has also emerged within the field, however generally not yet incorporated into the state regulatory system. For example in 2005 the State of Texas legislature passed a bill to accept third-party surveys in senior living facilities (in place of state surveys), however by 2013 no third-party surveyors had yet been designated by the state.

In September of 2000, U.S. Congressman Pete Stark brought forward a proposal for a White House conference to incite a national discussion on quality of care in assisted living facilities. In 2007 during a two-day

congressional hearing “prompted by concerns that quality at nursing homes was declining” Senator Ron Wyden asked why its easier to buy a washing machine in the United States then to choose a nursing home (Duhigg, 2007, November 16).

As exemplified by Senator Wyden’s statement, regulation and quality monitoring mechanisms in aging services have become quite complex and controversial. In 2009, in response to Senator Wyden’s remarks, Medicare set up their own five-star rating system for nursing homes, in order to help consumers navigate the array of different private accreditation and rating systems that have emerged over time (Thomas, 2014, August 24). However the Medicare system has been heavily criticized recently (see Thomas, 2014, August 24), and regulation of this industry remains contested.

Overall the aging services industry in the United States (as elsewhere) is booming and thus competition and pressure for growth by providers and investors is intense. Accordingly, private accreditation and rating-systems are quite significant in this market, as consumers, funders, and State governments seek credible mechanisms and sources of information for quality monitoring. As described by Maribeth Bersani (2013, p. 50), in an issue of the Senior Living Executive magazine, accreditation issues at the state level are one of the industry’s most immediate governmental priorities.

In all program areas in which CARF operates, competition between private accreditation bodies continues to increase. More so, in some sectors private accreditation in general is on the decline. A study published in 2004 by Holleran Consulting determined that there was an 8% decrease in long-term care facility accreditation between 1999 and 2004, along with a 20% decrease in respondents that considered accreditation as ‘extremely valuable’ (Naditz, 2004, October 1). However this study also

demonstrated that while the number of facilities using Joint Commission (JCAH) accreditation had decreased significantly, the proportion of facilities using CARF-CCAC had increased from less than 1 in 4, to more than 1 in 3 (Naditz, 2004, October 1).

At the same time, as described by a previous Board member, “in the Community and Employment Services area...CARF is losing market share to other accreditation bodies” (Participant 4). One of the main competitors that CARF is losing market share to in this field is the Council on Quality & Leadership (CQL):

“They (CQL) are going at it two ways – they're telling providers, we can give you independent third-party accreditation, and at the same time they are going to the state and saying we will let you have these standards that we have developed for a fee, and then you can do it (apply them)...They have been extremely aggressive in going to states and saying – we will sell you these components of our quality assurance system that you can use as an alternative to other accreditation bodies” (Participant 4).

Overall in each of the different program areas the market, as well as the competition is constantly evolving, and thus the context in which CARF currently operates is highly dynamic and complex.

Governance & Leadership

The third phase of CARF's evolution began with a transition in leadership, from Dr. Donald Galvin to Dr. Brian Boon. As described by a Board member at the time, “He (Dr. Galvin) decided to retire, and Brian Boon—who at the time was working for a workers compensation organization in Alberta, and was on the Board for CARF—expressed an interest in taking over for CARF, and he was eventually selected to do that” (Participant 5). Dr. Boon had been involved with CARF since 1990, when he began as a surveyor, and had been elected as at-large member on the Board of Trustees in 1998.

Another major change that occurred at CARF during this period of time was a multi-year governance review that resulted in a restructuring of the

Board in 1996. Through this restructuring, the 50+ member Board of Trustees was scaled down to an 11-member Board of Directors, which significantly altered the governance structure of the organization. Prior to the restructuring, the structure of the Board of Trustees was the same as it had been throughout the 1990s and earlier—the Board was made up of representatives appointed by sponsoring member organizations, as well

Evolution of the Board of Trustees/Directors (select dates)

2003:

19 At-large Member; 33 Sponsoring Member Appointees

Sponsoring Member Organizations (1 member each)

- *American Academy of Neurology*
- *American Academy of Orthopedic Surgeons*
- *American Academy of Orthotists & Prosthetists*
- *American Academy of Pain Medicine*
- *American Academy of Physical Medicine and Rehabilitation*
- *American Association of Homes & Services for the Aging (AAHSA)*
- *American Association of Spinal Cord Injury Psychologists and Social Workers*
- *American Hospital Association*
- *American Network of Community Options & Resources*
- *American Occupational Therapy Association*
- *American Physical Therapy Association*
- *American Pain Society*
- *American Psychiatric Association*
- *American Psychological Association*
- *American Rehabilitation Association*
- *American Speech-Language-Hearing Association*
- *American Spinal Injury Association*
- *American Therapeutic Recreation Association*
- *Assisted Living Federation of America*
- *Association of Rehabilitation Nurses*
- *Brain Injury Association of America*
- *Department of Veterans Affairs*
- *Goodwill Industries International*
- *Intl. Association of Psychosocial Rehabilitation Services*
- *Mental Health Corporations of America Inc.*
- *National Adult Day Services Association*
- *National Association of Alcoholism and Drug Abuse Counselors*
- *National Association of Social Workers*
- *National Council for Community Behavioral Healthcare*
- *International Association of Jewish Vocational Services*
- *Paralyzed Veterans of America*
- *United Cerebral Palsy Associations*

2006:

11 At-large Directors

as at-large members elected by the Board. The committee structure was also still in place, and “most of the work was done through the committees (Participant 5).

The full Board would meet several times annually for 2-3 days and according to a Board member during the 2000s:

“You’d first have the general meeting with everybody...and then you’d break up into your committees, and you’d spend the next day going to committee meetings...and then on the last day we’d all come together, and the committees would make reports, make recommendations, and the full Board would take action on those recommendations” (Participant 5).

Figure 9: CARF Board of Trustees (2000s)

Certain changes did occur with the Board of Trustees however, between when Dr. Boon took over as Director/CEO, and the Board restructuring. The Board of Trustees continued to grow, from 47 members in the year 2000 (34 from sponsoring organizations; 13 at-large), to 52 members in 2003 (33 from sponsoring organizations; 19 at-large). Another change brought in by Dr. Boon was the adoption of the 'policy governance' approach, which is "a management system...that very clearly defines the different roles of the Board and staff – the Board's role is to set policy—define a set of outcomes—and the staff's role is to implement it, but it's not the Board's role to tell the staff necessarily how to implement it" (Participant 4). As described by a Board member during the early 2000s, policy governance is what allowed a Board of this size to function, "because you can't have fifty Board members with slightly different opinions telling the CEO how to do something" (Participant 4).

The governance review that resulted in the Board restructuring began formally around 2004; however the debate over whether the fifty-member board was too large to function had begun in the year's prior. As described by an interview participant: "One of the first things he (Dr. Boon) wanted to do, along with a cadre of Board members, was to reduce the size of the Board to a manageable number, and eliminate the opportunity to 'buy' seats, which is what the founding (sponsoring) agencies really had" (Participant 5). According to another interview participant:

"There were two sides involved, where some were saying - we need to stay this size and have all of this representation in order to truly represent the fundamental values of CARF and to carry those forward. And then others were saying that you just can't work with this huge Board of Trustees, and that it gets in the way of, primarily coming from the CEO, his ability to very quickly respond to opportunities that he saw" (Participant 4).

Thus after a "couple of years of struggling with that question", an idea came forward from some of the Board members to create a smaller Board, that would not necessarily include all of the affiliated organizations,

as well as a parallel entity called a national advisory council (Participant 4). The intention, according to an interviewee was that at least 1/3 of the Board members would come from the membership of the advisory council, in order to “ensure the ongoing basis of people who were actually involved in the field as having governance authority within CARF (Participant 4).

At the meeting of the CARF Board of Trustees in August of 2004, the Board voted in favor of the “governance redesign principles”, and to adopt the newly proposed by-laws related to the governance redesign to be effective January 1, 2006 (CARF, 2004). The governance redesign created a new 11-member Board of Directors, and transitioned the ‘sponsoring member organizations, and the ‘associate member organizations’ onto an ‘International Advisory Council’.

Following the Board redesign, the Board generally meets three times annually, and “addresses issues as a Board as opposed to in committees”, although sometimes they “have ad hoc committees that dealt with specific things that required some deeper investigation” (Participant 5). For major decisions the Board still has the power of approval, such as “when there would be an idea about expanding into a different area of accreditation...or with starting the office in Canada and providing services in other parts of the world”, however the Board of Directors is no longer involved in developing or approving the standards (Participant 5). As described by a Board member from the years following the redesign: “we played an advocacy role in the sense that we were able to identify other organizations that might be a good fit with CARF, either for accreditation or for collaborative efforts” (Participant 5).

The International Advisory Council (IAC) was also formed as part of the governance redesign. According to an interview participant:

“The Board was downsized initially, but that National Advisory Council is in many ways not functioning in the way that we envisioned it to function. We

envisioned it to be – one of the things that happened at CARF board meetings was that all of these entities from throughout North America got together 3 or 4 times a year and shared ideas, and interacted with one another, and then we also governed CARF. We saw the new outcome to be somewhat parallel, where this entity – the National Advisory Council, would still provide that forum for its members, plus it would nominate people to the CARF Board. Neither of those has happened. ... We had thought that a third of the members of the Board would come from that (the IAC), and I believe as finalized things that language was sort of modified to be made a little bit less clear on that” (Participant 4).

Within the principles adopted by the Board vote in 2004, the IAC was named the ‘Assembly’, and as described, #7 of the principles adopted states: “At least 1/3 of the Trustees shall be drawn from the Assembly” (CARF, 2004), and thus the term ‘shall’ does not hold any legal requirement. While the IAC has never had a meeting since the restructuring, it still has a function in that “all of the revisions to standards go out to each of the IAC members, with the opportunity to provide input on them” (Participant 4). Thus the current role of the IAC is generally to “rubber stamp things” (Participant 7).

Following the Board redesign, there was also a change in the relationship between the Board and the CARF staff. As described by an interview participant, the communication between staff and Board members decreased significantly, and many of the roles that had been taken on by the Board in the previous decades CARF were subsumed by staff in the internal leadership team (Participant 6). According to another interview participant, generally the President/CEO now acts as the channel of communication between staff and the Board (Participant 7).

Operations & Business Practices

The business structure of CARF during this third phase has remained similar in the sense that the separate program divisions created by Dr. Don Galvin in the 1990s still exist, however they have been rearranged and expanded, and renamed as ‘customer service units’ more recently.

Certain changes did come about in terms of staff management, as described by an interview participant:

Dr. Boon brought in an outfit called Accenture out of Canada, it was an IT system that was making sure that everybody was watched, it knew the keystrokes, so that you know when people started work and when they left. No families in the facility, who called home, and pretty soon everybody was kind of distant from one another (Participant 6).

Since Dr. Boon took over CARF has also opened a second office in the United States, in Washington, D.C.

In 2002 CARF-Canada was separately incorporated in Edmonton, Alberta. By this time the market in Canada had grown substantially, and as described by an interviewee: "business wise, the laws in the U.S. and Canada are different so its just easier to run business in Canada by being incorporated separately" (Participant 7). CARF-Canada has it's own President/CEO, as well as two-member Board of Directors, however "overseeing the organization (CARF-Canada) is the larger Board of Directors for CARF-International" (Participant 7).

In terms of operations, CARF-Canada generally operates as a unit of CARF-International, however as described by an interviewee, "we're really all one organization...our IT department is there (CARF-International), our finance department, our communications and marketing department, all our resource specialists" (Participant 7). The role of CARF-Canada is thus to support Canadian organizations, organize education and trainings in Canada, do business development and grow the Canadian market: "We're set up to inform the bigger picture of CARF on Canadian issues, and we have Canadian surveyors, Canadian advisory councils on standards development, so we can recruit that kind of intelligence and people from the field" (Participant 7). In 2011 CARF-Canada opened a second office in Toronto, Canada, and currently there are four professional staff and one support staff working for CARF-Canada (Participant 7).

Another major event during this phase occurred in early 2003, when CARF acquired the Continuing Care Accreditation Commission (CCAC). The American Association of Homes and Services for the Aging (AAHSA; *renamed LeadingAge in 2011) founded the CCAC in the mid-80s, as an accrediting body for aging services providers (Brommel, 2006, p. 52). CARF collaborated with the CCAC in the late 1990s to help develop standards for adult day care and assisted living, and as described by an interview participant the acquisition came about as “the CCAC was kind of concerned about looking at themselves (their members), a potential conflict of interest...they were beginning to realize that it was better for someone from the outside to come in” (Participant 6). CARF-CCAC now operates as a customer service unit within CARF, and is based in the Washington, D.C. office.

By 2008 CARF’s operations had grown into seven separate customer service units: “aging services & CARF-CCAC; behavioral health; DMEPOS; employment and community services; opioid treatment program; medical rehabilitation; and CARF-Canada” (CARF-International, 2008). In 2009, CARF’s child and youth services program area had grown into the eight customer service unit.

Standards, Accreditation, and New Products

Prior to the restructuring of the Board, the standards were developed through the same process as in the 1990s—national advisory committees would be formed to develop or revise standards, which would then go to the Board Standards Committee for review and approval (Participant 5). Following the restructuring of the Board in 2006, the development process is similar however instead of going to the Board standards committee for approval, the International Advisory Council

(IAC) approves them. The current standards development process, as described by an interview participant, is as follows:

“Starting at the beginning, let's say there's a need, someone says 'we need long-term standards in aging care services'. What happens is people that are experts in the field internationally...would sit at a table and basically put together the standards. All the staff does would be to moderate that. So then we take those standards, and we send them back out to the people that were on that committee and they would tweak them. Then they would go out for wide field review, so to the experts in the field—CARF accredited, not CARF accredited—get that input. Then they become standards and they're published. Then they are constantly being evaluated by the organizations themselves, by ministries, associations, staff, other stakeholders, and every year (late in the year) we have a committee that goes through all of those evaluations. Our research department puts everything together and the standards are adopted, and then the whole process starts all over again for the next annual year” (Participant 7).

As mentioned by this interviewee, the standards are reviewed and revised annually. During this phase of CARF's operations, many new standards have also been developed, expanding the range of service providers accredited by CARF. In 2005 CARF published the first Child & Youth Services Standards Manual (for child welfare/protection agencies), and in 2006 standards for dementia care were published. In 2013 new standards were developed for eating disorder treatment programs. In 2007 CARF began accrediting Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, following the approval of CARF as a national deeming authority recognized by the Centers for Medicare & Medicaid Services (CMS).

CARF has also developed a range of new standards and products/services related to business management and administration. In 2003 CARF developed standards on governance structures and Board of Directors practices (CARF-CCAC, 2014, p. 3). In 2007 CARF also developed a new product called uSPEQ, described as “a neutral, third-party resource to anonymously capture your consumers' and employees' feedback” (CARF-International, 2014b), it is a data collection and reporting system for both consumers and employees. In 2008 CARF

developed a new quality framework for organizational management called 'ASPIRE to Excellence', which was included into all of the standards manuals.

One of the most significant areas of growth in standards, accreditation, and the development of new products began when CARF acquired the CCAC in 2003. With this move, CARF also acquired the standards that had already been developed by the CCAC for Continuing Care Retirement Communities (CCRCs) as well as Aging Services Networks, which added to the aging services standards that CARF had already developed for adult day services, assisted living, and long-term care homes (CARF-International, 2005, p. 12-13). In 2009 CARF was also in the process of developing standards for home and community-based aging services (Irving Levin Associates Inc., 2009). The accreditation requirements for aging services also have specific financial standards that are developed through the input of CARF-CCAC's Financial Advisory Panel, including annual reporting requirements for margin/profitability ratios, liquidity ratios, and capital structure ratios (CARF-International, 2014c). The Financial Advisory Panel is comprised of "leading finance experts" (CARF-International, 2014d), including representatives from the institutions that collaborate with CARF to produce the research and publications described below.

Along with the expansion of standards and accreditation for aging services, CARF has developed new products in this field, specifically including research publications on the finances of senior living providers. From 2009 onwards CARF-CCAC has collaborated on several different studies and publications on financial ratios and trends within the field, including with the National Adult Day Services Association (NADSA), Ziegler Financial, and ParenteBeard LLC (a national accounting firm). The products include an annual study to calculate financial ratios for adult

day services, a financial benchmarking study for adult day services, an extensive report entitled “Financial Ratios & Trends Analysis of CARF-CCAC Accredited Organizations” (published in 2013), which provides industry benchmarks on financial trends in the aging services field (CARF-CCAC, 2014). Also in 2013, in collaboration with CARF-CCAC’s Financial Advisory Panel, CARF developed a website targeted at lenders (see CARF-International, 2014c), to support accredited organizations in obtaining capital for major projects for aging services facilities (CARF-CCAC, 2014, p. 4).

Growth

The impetus for growth came from both the CARF CEO as well as the Board. As described by a former Board member, prior to the restructuring in 2006:

From the Board level, we promoted growth and expected growth. Now where the difference may come is for example with the mergers, which were growth into different sectors, versus growth within the sectors that we were already operating in. So at the board level we felt that a certain level of growth was necessary, I'm not sure all of us were that supportive of the mergers, but the actual growth” (Participant 4).

However following the rescaling of the Board of Directors, Dr. Boon moved towards expanding the scope of CARF with the support of the new 11-member Board of Directors:

“After we got the Board down in size, he (Dr. Boon)...looked to get into more areas of human service. He had many meetings with people providing aging services, employment, other medical services, and gradually was able to achieve that goal of expanding the scope. He also wanted to have CARF have a greater presence in Canada. And we (the Board) supported that very strongly” (Participant 5).

This strategy has contributed directly to the growth of CARF, “by expanding the areas of accreditation...it has created a larger playing field of which you can recruit agencies to be accredited, that helped with the growth” (Participant 5).

Another change occurred in the strategy for achieving growth and expansion during this phase of CARF's evolution, as a result of the governance restructuring. Previously, as has been described by several interview participants, the CARF staff—and specifically the Directors of the program divisions—worked closely with the network of Board of Trustee members, in order to expand the reach of CARF accreditation. The new approach to business development following the restructuring generally shifted that responsibility to CARF staff, who utilize numerous strategies in order to promote CARF and grow the business.

A major aspect of this work, as described by an interview participant, involves holding informational sessions, meeting with stakeholders, exhibiting and presenting at conferences, and presenting on panel discussions—the focus is on education and information sharing, as well as “finding out what's going on politically, finding out what the pulse of that sector is...just having relationships with professional associations” (Participant 7). As an example, CARF representatives are often invited to speak on a panel with other accreditation bodies, in areas that either have or are considering a mandate for service providers.

Another important focus is to “keep on top of regulations” and the different mandates and requirements of government ministries and professional associations: “every setting has a lot of different professional associations, and their ministries are very complicated” (Participant 7). This information is often used to inform CARF standards as well as the marketing and communications materials:

“We do ‘Crosswalks’, which means that we take our standards, and we take a set of regulations and we compare them. For instance recently we did the Canadian Homecare Association – ‘Principles of Homecare’ document, that's their guiding principles. So we took those and ‘cross-walked’ them with our homes and community services standards to show that there is parallel agreement, and that if an organization was accredited with CARF, they're not reinventing the wheel” (Participant 7).

More so, along with research related to the standards, the research department at CARF performs market research to inform the business development activities of the organization: “We have a huge research department so they are constantly evaluating standards, evaluating statistics, those sorts of things that will help us to know who we are reaching and who we aren't reaching” (Participant 7).

In 2013, over 6,500 organizations throughout the world had CARF accredited programs (Ellis-Lang, 2013, p.5). The Community & Employment Services Unit is the largest (Participant 7), however the Behavioral Health unit has also grown substantially, since the early 2000s, largely under the direction of the unit's previous Director, Nikki Migas (Participant 4). The United States is still by far CARF's largest market, with the largest presence in states such as California, Florida, Illinois, Michigan, North Carolina, and Ohio (Ellis-Lang, 2013, p. 6). The United States Department of Veterans Affairs (VA) is currently CARF's largest client (Participant 7).

CARF Canada has also seen substantial growth during this phase of CARF's operations. The Canadian market now makes up approximately 10% of CARF's business, and the British Columbia Ministry of Children & Family Development (MCFD) is now CARF's second largest client (Participant 7). As such, direct contracts with government agencies—i.e. the U.S. Department of VA and British Columbia's MCFD—are now the most significant area of CARF's business.

CARF has also exhibited quite a bit of expansion into the international market in recent years. As described by an interviewee, this has primarily occurred through the Medical Rehabilitation Unit, which for the past decade or so has an 'International Director' to develop this market (Participant 6). In 2005 CARF accredited its first program in South America, and in 2008 the first program in Oceania as well as the Middle

East. In 2009 CARF accredited its first program on the Asian continent and in 2010, the first program on the African continent.

The CARF-CCAC and Aging Services Unit of CARF has also been a significant area of growth, as it was only in the inception stages when Dr. Boon took over as CARF's Director/CEO in 2001. According to Sue Matthiesen, (then) Business Development Manager of CARF-CCAC, by 2004 this unit of CARF "typically sees a 7-8 percent overall account growth across all of the programs" (quoted in Naditz, 2004). More so, this area of CARF's business is less reliant on government mandates as an incentive for providers to seek accreditation, as there is significant demand from consumers for quality assurance and ratings systems.

The financial position of the organization has also grown significantly during this third phase of CARF's operations. From 2002 to 2012, CARF's total liabilities and net assets have grown from approximately \$8 million to \$28 million, in 10 years.

Mandates

According to an interviewee, approximately 70% of organizations that currently seek CARF accreditation are either required through policy or legislation, or receive a financial incentive from the government (Participant 7). Therefore while some organizations seek accreditation for other reasons, government mandates play a substantial role in CARF's business. In order to develop mandates, CARF representatives are firstly involved in promoting the value of private accreditation to state representatives and other industry leaders. As described by a former Board member:

"One of the things that I think accreditation offers, and I'm constantly waving this banner at state meetings, is that it's so much less expensive and more effective to have external third party accreditation, than to have a state office of quality assurance with all of the support needs that that carries to do the same thing" (Participant 4).

The next step, once a state agency or ministry has adopted private accreditation, is to have CARF identified as a recognized accreditation option: “when the ministry embraces accreditation, then being at the table to be able to put a proposal forward that our program (CARF) matches the ministry’s goals or enhances them” (Participant 7). One example is the strategy CARF employed to become recognized by the Ontario (Canada) Ministry of Long-term Care:

“Traditionally long-term care homes in Ontario had been accredited with Accreditation Canada. Not all of them, it was voluntary and still is, but when they are accredited there is a funding premium, so that gives them (providers) the impetus. In 2008 there was a study done, a pilot project basically, where some homes worked with CARF. When the results of that were put together, the Ministry accepted CARF as a choice, giving homes the choice between Accreditation Canada and CARF. Since then about 1/3 of the homes are accredited with CARF, and slowly but surely our market share is increasing in that area” (Participant 7).

As the largest market for CARF’s business, the majority of government mandates for CARF accreditation are in the United States. In 2013, CARF had achieved recognition in approximately 48 U.S. states under mandated or ‘deemed’ status in legislation or regulatory policy (Ellis-Lang, 2013, p. 5). As mentioned above, CARF now has an office in Washington D.C., whereby “the role of the person running that office is to influence government about requiring accreditation and improving service that are offered by agencies” (Participant 5).

CARF has also received significant support from industry associations in helping to gain mandated status. In 2013, the Texas Assisted Living Association (State chapter of the Assisted Living Facilities Association-ALFA) sponsored a bill (HB 1971) in the Texas State Legislature, to create a pilot project between CARF and the Texas Department of Aging and Disability Services, with the goal of getting CARF certified as a surveyor. The bill was accepted and signed in to become effective on September 1, 2013. The ALFA chapter in New York State has also been actively lobbying for the state to grant CARF ‘deemed status’ to regulate

assisted living communities (Bersani, 2013, p. 50). CARF has now achieved state mandates in aging services in numerous states including the District of Columbia, Florida, Arizona, Illinois, Iowa, and Nebraska (see CARF-CCAC, 2012).

Over this phase of CARF's operations the organization has been recognized for two separate federal mandates. In 2006 CARF applied and was accepted as one of 10 accreditation systems for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) funded by the Medicare Part B program, and suppliers were allotted three years in order to achieve accreditation. A second example in the field of child and youth services, in June 2009 the *Medicaid Services Restoration Act* was introduced to U.S. Congress, and s. 1217 defined therapeutic foster care covered by Medicaid, and included accreditation—by either the Joint Commission (JCAH), CARF, or the Council on Accreditation (COA)—in the definition.

Numerous state mandates also came about during this period. In 2009 the State of California adopted a regulation (CA Code Title 9, Div. 3 Chap 11 Sec 7331) requiring public and private non-profit rehabilitation facilities offering vocational programs and services be accredited by CARF. Accreditation by CARF is also required for for-profit “vendors of habilitative services”, in order to be state vendors of such services (CA Code Title 17, Div. 2 Chap 3 Sec 54310). In 2011, the State of Vermont proposed a rule that required accreditation from CARF or the Joint Commission (JCAH) for opiate treatment providers. The state of Pennsylvania, as well as the State of Alaska have also brought in mandates for accreditation in the behavioral healthcare sector, and recognized CARF as an accreditation option. At the same time, as described by an interviewee, there is a lot of turnover in the state mandates, and certain states such as Colorado, now offer waivers for

their mandate on vocational rehabilitation service providers, which has decreased the number of organizations seeking accreditation (Participant 4).

Since 2000, there has also been a significant increase in government mandates and recognition in Canada. In 2004, the Alberta Ministry of Human Services – Children and Family Services designated CARF-Canada as a recognized accreditation body, and the Provincial ministry provided funding for accreditation for contracted agencies providing children's services (Brommel, 2006, p. 52). By 2012 Alberta Health Services required that contracted service providers of long-term care, supportive living (assisted living), and home care, are accredited by an approved body, which includes CARF (CARF-CCAC, 2010, p. 9).

In 2006, British Columbia's Ministry of Children & Family Development (MCFD) and Community Living BC (CLBC) renewed their accreditation mandate for contracted service providers, and in 2014 Community Living BC (CLBC) has negotiated an agreement with CARF to begin an evaluation for the possibility of accrediting CLBC itself. In 2008 the Ontario Ministry of Health and Long-term Care recognized CARF as an accreditation option, and in 2009 CARF accreditation was recognized by the Alberta Ministry of Health and Wellness.

Following the opening of the new office in Toronto, Ontario, recognition of CARF accreditation in Ontario has also grown substantially. Currently in Ontario, along with the Ministry of Health and Long-term Care, the Ontario Association of Residences Treating Youth (OARTY) lists CARF as an accreditation option for its members. Also, the Ontario Community Care Access Centres (CCACs) recognizes CARF as an accreditation choice for both the CCACs as well as contracted service providers. In this case accreditation is mandated for contracted service providers. Further, two of Ontario's Local Health Integration Networks (LHIN)—Central West

and Mississauga-Halton—mandate accreditation for any programs that they fund, and recognize CARF as one of the accreditation options (Participant 7).

DISCUSSION

The following section presents several key themes that emerge from contextualizing the historical evolution of the Commission on Accreditation of Rehabilitation Facilities (CARF) with the literature review presented in this major paper.

Initial purpose of developing standards and accreditation

In describing private regulatory institutions, Bartley (2007, p. 309) states: “institutions arise out of political, cultural, or professional projects”, and in this way are a manifestation of the interests of those advancing the regime. The impetus to develop standards and accreditation that led to the formation of CARF came from two main sources. First, within the two provider associations – the Association of Rehabilitation Centers (ARC) and the National Association of Sheltered Workshops and Homebound Programs (NASWHP), there was the sense that some level of quality standards needed to be established for operations and management of facilities (Participant 6). Second, Ms. Mary Switzer, the Director of the Federal Vocational Rehabilitation Administration, had a major influence in the formation of CARF, and funded the development of standards by the two organizations, ARC & NASWHP, prior to the founding of CARF.

The CARF example seems to slightly contrast the development of standards by the seven accrediting programs researched by Nichols (1980). As described by Nichols (1980, p. 53-67), the main drive to develop

standards and accreditation came from professional leaders and member agencies of professional and provider associations. In these examples, alongside quality improvement, developing standards and accreditation was seen as a way to carve out the parameters/qualifications of a specific profession, and thus advance the position of that professional/provider group. The external forces of increased funding and accountability demands from government were seen as less influential within these seven examples. Contrarily, Ms. Switzer was described numerous times as the 'visionary' behind the development of standards and accreditation within the rehabilitation sector, along with the formation of CARF more specifically.

This seems more in line with governance theory that highlights government impetus for accountability (see Brunet-Jailly & Martin, 2010). It also coincides with a significant portion of the literature on transnational private regulate (TPR), which posits that the involvement of private actors in regulation is more complex than a unidirectional process of 'privatization'.

Accreditation as private regulation

The founding of CARF was predicated on the belief—both within the industry as well as from within government—that the private sector was better suited for developing and administering standards and accreditation in the rehabilitation sector. This was the vision of Ms. Mary Switzer (the Head of the Federal Vocational Rehabilitation Administration-VRA), who saw the entire VRA program as a partnership between government and service providers. From within industry, as proclaimed by

the National Institute on Workshop Standards (quoted in Nelson, 1971, p. 170):

“Self-regulation would be better than government regulation by forfeit; that the workshop movement itself was better equipped to develop evaluative standards and criteria; that the workshop movement could best formulate a basis for ongoing development of future standards...and could best implement such standards and criteria via a national accreditation program or by some other means”.

This positive image of CARF as a model of private accreditation held up over time. As described by Alan Toppel in 1976 (p. 21): “the Congress now has the confidence that the rehabilitation facility movement has the collective capability within the voluntary sector to raise the level of performance and maximize tax dollars appropriated”. By 1981, when President Reagan recognized the fifteenth anniversary of CARF, he described CARF as “a national example of the private sector meeting public needs” (CARF, 2014e). Further, many of the interview participants communicated why private, ‘third-party’ accreditation was viewed as superior to state certification (described below).

At the same time, as described by an interview participant, CARF realized early on that “incentives and consequences”, through state recognition and mandates would be essential to the uptake of accreditation by providers (Participant 2). In reference to the three models of accreditation proposed by the Institute of Medicine (2001), the intention was/is to shift from accreditation as a supplement (addition) to government regulation, to accreditation as a substitute (replacement) to government accreditation. This realization was common amongst accreditors by the late 70s and early 80s, as the study by Nichol (1980, n.p.) identified both “pressure to make accreditation a condition for receipt of funding” and “a trend away from in-house and toward third-party accreditation” as major priorities for the seven accrediting bodies included in her study.

In general, CARF has experienced significant overall increase in government mandates and recognition from its founding in 1966 to the present day. The different ways this has manifested includes for example: requirements for CARF (and possibly other) accreditation in order for providers to be eligible for government funding; funding incentives or bonuses for achieving accreditation; and the requirement of accreditation in order to be licensed as a service provider. This increasing prevalence of accreditation as a component of state policy or legislation is based on a number of reasons. For one, it was viewed as a more efficient and economical option, as described by Terry Etling, who was head of the Facilities Division within the Ohio State Rehabilitation Agency during the 1980s:

"I was the one who decided that on balance, even though the standards that we (the state agency) had developed were okay, I thought that going forward we were going to be better off if we participated in a national program...I didn't think we could compete with a full-time organization that was in the business to apply standards and keep them current...I also thought it was going to be more economical in the long run" (personal communication, October 24, 2014).

A second interview participant involved with the organization more recently echoes this sentiment:

"One of the things that I think accreditation offers...is that its so much less expensive and more effective to have external third party accreditation, than to have a state office of quality assurance with all of the support needs that carries to do the same thing" (Participant 4).

Another rationale for private accreditation as a substitute for government regulation/certification brought forward through the interviews was the potential conflict of interest and politics of a publicly administered program. One interview participant described the pressure that the Director of a State Vocational Rehabilitation Agency would get from local politicians to certify agencies that were important within their constituency. By implementing a state mandate for accreditation, "it gave him some insulation" (Participant 2).

In relation to the literature on accreditation, these descriptions of CARF fit with the assertion of the Institute of Medicine (in Brommel, 2006, p. 24) that private accreditation benefits the public and government as a means of “reducing the cost of oversight”, and the ability to be “more flexible and responsive to change”. At the same time a main rationale for this reduction in cost that is proposed by the Institute of Medicine (2001) is that organizations pay for the accreditation process themselves, as opposed to a tax-funded state-run program. Yet in general, the majority of organizations that are accredited by CARF under state mandates receive compensation from the state, at least for the cost of the accreditation process itself (not the additional administrative costs related to following the standards).

Cost is a major factor that has impacted state decisions to implement and maintain mandates, which could arguably be seen as a challenge or critique of private accreditation. As an external, and thus somewhat ‘elective’ cost, in reality CARF accreditation oscillates between the two models of accreditation proposed by the Institute of Medicine (2001)—from substitute to supplement—thus CARF accreditation—as a quality assurance mechanism—is somewhat precarious under this system.

The way in which CARF accreditation has been incorporated into state policy/legislation over time also fits in with the writing of Harclerod (1980), who described accreditation within the field of higher education as the interactions between a triad of actors—professional associations, state governments, and the federal government. In general in the United States, state mandates and recognition of CARF accreditation have been rooted in federal policies/legislation related to the requirements for federal funding, for example quality assurance requirements. In this way, as purported by Harclerod (1980), the federal government has a significant degree of control/influence over the whole process. This could

provide some additional insight into CARF's recent decision to open an office in Washington, DC.

The increasing incorporation of CARF accreditation into government regulation also fits with the broader literature on regulation, which describes the shift towards more complex 'assemblages' or 'infrastructure', whereby governance is accomplished through a web of state and non-state actors (see Salter & Salter, 1997; Brunet-Jailly & Martin, 2010, p. 8-9; Sassen, 2008).

A major change that should be recognized in looking at CARF as a private accreditation body is the significant restructuring of the organization that occurred in the mid-2000s. While the details are discussed in more detail below, the influence and involvement of the private sector—i.e. 'sponsoring organizations'—has decreased significantly in recent years, so the question could be asked around how 'private accreditation' is defined. Galvin (1999, p. 6) described accreditation bodies as "derivatives of the field or industry that they are to monitor". Yet, this relationship of 'derivation' has changed significantly in recent years. Arguably CARF may no longer fit as an example 'self-regulation'—i.e. industry self-monitoring—if the industry being regulated is no longer directly involved in the regulatory institution.

Governance structure

In the early 2000s, CARF undertook a review and restructuring that significantly changed the governing structure of the organization. Prior to the restructuring, CARF was governed by a Board of Trustees that had grown to 50+ members, the majority of which were appointed by sponsoring member organizations. These sponsoring member

organizations represented a wide range of sectors, as well as not-for-profit, for-profit, and government service providers. Following the restructuring, an 11-member Board of Directors was established, and the role of the Board was defined to focus primarily on 'high-level' strategic planning and vision for the organization, whereby the CEO has much more autonomy to direct the organization (Participant 5).

The main rationale for the change was that the Board of Trustees had become too large to function. Different interview participants described this to varying degrees, whereas one interviewee stated: "you couldn't get anything done" (Participant 5), another described the large Board as "somewhat cumbersome" (Participant 4), however there was agreement that 'efficiency' was a main motivating factor in the restructuring. Another critique was the notion that sponsoring member organizations were "buying" seats, whereby when the Board was scaled down "people all thought that their fellow board members were committed to the best interest of CARF, not to whatever else they were representing" (Participant 5). Another point that was made, was that the CEO at the time wanted to reduce the size of the Board in order to be more "agile...to change the organization" (Participant 4), and to "respond to new opportunities" (Participant 5).

There were also several critiques of the restructuring brought forward in the interviews. As described by one interviewee, the large Board was a significant asset in promoting CARF accreditation:

"There is tremendous power in collaboration, input, debate, and discussion. And once everybody felt like they contributed, whether they felt like their idea was taken or not, they felt like they'd been heard. And that's an important thing to any kind of national association, non-governmental organization, to hear people out, so that they're feeling like they've been heard at the highest level. I never once found them to turn around and not help you out, even after they'd had an argument with each other on a philosophical point. On the whole, they felt like the big long-range vision was people living in the community, working in their community; they felt like 'this is my group'. So whether they split their hair over the finer parts didn't matter, the big point was they had a higher vision, and they felt like they were

contributing to it. And, that their job was to turn around and go home and talk to their 500 members and be able to convince them that this was the way to go, and this was what was going to need to happen next" (Participant 6).

As a result of the shift, one interview participant stated that the act of promoting and furthering the reach of CARF became substantially more difficult, and involved more of a 'sales' approach, as opposed to expansion through personal networks (Participant 6). This was a possibility raised by Brommel (2006, p. 256) in the case of the COA, whose findings suggest "the absence of a formal relationship with the professional social work organizations may have been a contributing factor to the challenges COA faced in achieving legal recognition and marketing to prospective service agencies".

Further, while the vision of the restructuring was to continue providing an active forum for involvement for the outgoing sponsoring member organizations through the International Advisory Council (IAC), several interview participants communicated that the IAC does not play a strong role in CARF, and the membership have never had a formal meeting (Participant 4; Participant 5). More so, there was an idea that a portion of the Board seats would be filled by members elected by the IAC, in order to maintain some involvement by the provider associations in the governance of CARF, however that did not occur in the end (Participant 4). Overall as described by an interview participant: "a lot of people in the country feel that CARF is not as connected to the world of providers as they used to be. I've heard that a lot around the United States" (Participant 4).

The evolution of the governance structure of CARF has many parallels to that of the Council of Accreditation (COA). As outlined by Brommel (2006), the COA Board of Directors grew from representation solely of the two organizations that formed the COA (CWLA and FSAA), to a 25-member Board with 12 seats reserved for the CWLA and FSAA, and

the remainder of seats for national 'sponsoring organizations'. The number of COA sponsoring organizations continued to grow, and around the same time as CARF's restructuring, the COA Board of Directors was drastically reduced and a separate 'sponsoring advisory council' was formed (Brommel, 2006, p. 150-167). However according to Brommel (2006) the sponsoring advisory council has operated somewhat as intended, and appoints three members to the Board of Directors (Brommel, 2006, p. 174). The changes with CARF and the COA also fit within broader trends of increasing adoption of business practices in the not-for-profit sector (see Barzelay, 2001; Newman & Clarke, 2009).

What appears to have been missing from this debate so far relates to several of the other key themes. First, as the Board of Trustees historically had a large role in developing the standards, it functioned as an important forum for debate between different approaches to service delivery and professional groups, and a venue for achieving compromise, and (in theory) not allowing the values and priorities of one group to dominate over others. In this way the structure of CARF was an institution of self-regulation. Although CARF still represents a form of private, or 'third-party' regulation, it is arguably no longer as directly accountable to the industries that it regulates.

This raises an important concern from within the literature on accreditation. As stated by Malherbe (in Brommel, 2006, p. 32): "power rests not so much with the accredited but with those who control the process of accreditation". Further, "the nature of standards depends upon the objectives of the standard setters" (Nelson, 1971, p. 165). Previously the balance of power was spread more widely across the industries affected by CARF regulation, and the objectives and priorities of these actors would likely conflict and compete within the forum of the Board of Trustees. However following the restructuring the balance of

power is much more concentrated, and (for better or worse) less representative of the interests of the constituency affected by accreditation. Therefore the question should be raised of what are the driving goals and priorities of an organization that is now separate from the industry that it regulates?

Forum of debate

From its formation, a central characteristic of CARF differed significantly from many of the other accrediting bodies in the social/human services sector. To generalize, there are two main philosophical 'camps' in health and social/human services—the medical model, which generally takes an individual approach to cure or remedy a disability or personal barrier; and the social/support model, which take a more social/community approach to mitigate or reduce the negative impacts of a given situation (University of Leicester, n.d.). The majority of other accreditors, such as the Joint Commission (JCAH) and the Council on Accreditation (COA), were developed with a particular 'lens' or philosophical approach framing the standards and accreditation program. As an example, the COA was developed specifically to act as an accreditation option rooted in a social service model (Brommel, 2006). However as CARF was founded through a collaboration of two different provider associations—the ARC representing a more medically oriented approach and the NASWHP, with a more social/support-based approach—CARF itself became a forum through which this tension and debate played out.

"What oftentimes happened is you'd get these big, sometimes bitter arguments about what's the right way, what's the wrong way to take with the standards, and representatives from different national organizations wanted to provide us with their perspective and you never quite find the answer, other than a compromise in the language and sense of that standards" (Participant 6).

With the addition of 'sponsoring member organizations' on the CARF Board of Trustees, which represented a wide range of constituencies, many interview participants described the disagreements between these two broad 'camps', as well as more specific conflicts within particular professional or program areas.

"That tension has existed in the standards, and the various bodies for well over 50-60 years. The segments that are involved right now in the accreditation world— medical, employment and community living, children's services, behavioral health—all of them have the medical side and treatment, and the supports and services side" (Participant 6).

Further, as CARF began to expand the breadth of accreditation areas, particularly at the request of different constituency groups or sponsoring member organizations, even within the constituencies there would be conflict between different treatment approaches, the educational requirements to lead programs/facilities, and most significantly the measurements of success:

"What we found was that, when these people (behavioral health providers) were talking about standards the key issues for them, and the division point, was the way you evaluate a program. Is it whether or not they had caused people to stop drinking, period? And there was another part of the constituency that said no, we're looking for a recovery model, and that could be incremental in terms of people stopping drinking or using substances. That got reflected in the different standards and the approach to the whole area of outcome evaluation. And the persons who ran the program became important to them as well" (Participant 2).

In the mid-90s, the structure of CARF reorganized into three separate program areas, and also began issuing separate standards manuals for these three areas. According to an interviewee, this helped to alleviate some of the tension between different constituencies involved in accreditation, and allowed them to 'flavor' the standards based on the field of application (Participant 6). Also in the mid-90s, the American Rehabilitation Association, which had been formed through the merger of the ARC & NASWHP in the mid-70s, split back into two trade associations, the AMRPA, for facilities in the medical rehabilitation sector, and the ACCSES, for vocational rehabilitation providers.

What is entwined within these debates is a general conflict over professional legitimacy. Accreditation, and specifically specialized accreditation, has been criticized as a tool that professions use to “create a structural niche for a specialized labor force to have exclusive rights” (Wilson in Brommel, 2006, p. 33). However CARF in its historical form, whereby a broad range of constituent interests have been involved in developing and approving the standards (through the Board of Trustees), generally led to debate and compromise from the different perspectives (Participant 2; Participant 6). At the same time, CARF's new structure of governance (discussed further below), no longer offers the forum of the Board of Trustees as a meeting point for the different perspectives. It is yet to be seen what impact this will have on the philosophical underpinnings of the accreditation standards.

Competition

In the early years of CARF, interview participants describe the main competition as an accrediting organization as the Joint Commission (JCAH). Much of the early growth of CARF is attributed to the different approach that CARF standards and accreditation took:

“At that time (1987), there were only a couple of options for programs for people with intellectual and developmental disabilities, that being CARF and the Joint Commission. And most of the organizations, including myself, felt that CARF was a much better process for a community-base organization...we felt the CARF standards were really applicable at ensuring quality in a community-based program, whereas the Joint Commission was really more of a medical model” (Participant 4).

In 1976, Alan Toppel (p. 21), when asked what he thought would be the long-range impact of CARF, responded: I see a gradual unification and reduction of duplicative efforts by various licensing, certifying, and approving bodies into a single responsive accrediting organization for all

rehabilitation programs". At the same time, the behavior of CARF during this period of time was not overly competitive, as described by an interview participant – Goodwill Industries was basically using CARF standards within their own accreditation program (Participant 5).

As the number of accreditation programs grew in the 1990s and 2000s, competition became much more intense: "there has been a proliferation and growth of accreditation organizations to match the structural changes in the industry" (Edmunds et al., 1997, p. 214). In 1993 CARF sent a 'cease and desist' letter to the American Academy of Pain Management for using accreditation materials similar to CARF's, and in the late 1980s and early 1990s, CARF was involved in lobbying the Federal government to change the exclusive mandate for JCAH accreditation for a segment of behavioral health facilities funded by Medicaid.

The behavior of competing accreditation bodies is also becoming more complex and strategic. As an example, according to an interviewee, the Council on Quality and Leadership (CQL) is "going at it two ways" by offering organizations third-party accreditation, as well as "licensing their standards to the state quality assurance programs" (Participant 4). As described by an interview participant, "competition has gotten pretty intense in the last few years, and I think CARF...is losing market share to other accrediting bodies" (Participant 4).

Currently, in response to the heightened competition the CARF research department produces market research to direct the business development activities of the organizations: "we have a huge research department so they are constantly evaluating standards, evaluating statistics, those sorts of things that will help us to know who we are reaching and who we aren't" (Participant 7). CARF has also significantly expanded the scope of its business operations since the early 2000s. This has included expanding into new markets, such as aging services,

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), as well as new products beyond accreditation, such as financial research publications on the aging services sector. As described by several interview participants, CARF's growth strategy under the leadership of Dr. Boon (2001-present) has centered on "creating a larger playing field" (Participant 5).

The heightened competition between accreditation bodies is consistent with the overall trend of increasing "markets and market-mimicking devices" recognized within the literature on the transformation of the welfare state and public services provision (see Gelger & Wolch, 1986; Newman & Clarke, 2009). A concern raised by Brommel (2006, p. 33-36) regarding the potential issues arising from competition is that accreditation has become a mechanism through which competition for recognition or legitimacy among different professional groups plays out. As a result the number of different accrediting bodies representing different groups has expanded over time, with potential for redundancy, misguided priorities or resistance to change. Thus as argued by Brommel (2006) it is important to question what will be the effect(s) of the increasing competition between accreditation institutions. For one, as exemplified by the CQL, the impetus to modify the 'product' in order to be more 'marketable' or preferable could clearly impact the intention and substance of the standards and accreditation programs.

The International 'turn'

At a certain point in the history of CARF, the organization re-branded itself from the 'Commission on Accreditation of Rehabilitation Facilities' to 'CARF-International'. The concept of 'international' seems to

play out in CARF in two distinct ways. First of all, several interview participants commented on the prestige, stature or credibility that was affiliated with an 'international' organization. The growth of CARF's accreditation business was partly attributed to the view that accreditation from an international organization had more value than for example accreditation administered by a national (U.S.) provider organization (Participant 4; Participant 6). Aside from branding the organization, CARF also describes its standards as "international consensus standards" (Participant 7). In this way the discourse of 'internationalism' has acted to reinforce the framing of accreditation standards as 'universal' best practices.

Secondly as a business development strategy, throughout the history of the organization CARF has promoted accreditation outside the United States. This move towards developing the international side of the business began to grow under the leadership of Dr. Galvin in the 1990s, and has ramped up under the leadership of Dr. Boon, since 2001. Brommel (2006, p. 2164) also identifies the "expanding international market" as a key opportunity for the COA and social service accreditors. As described by an interview participant, the Canadian market for CARF accreditation now accounts for approximately 10% of CARF's business (Participant 7), and CARF has achieved multiple mandates in Canada (i.e. British Columbia and Alberta). CARF also has accredited agencies around the world, including Europe, Asia, Africa, and the Middle East.

In this way the CARF example does concur in many ways to theoretical writing on transnational private regulation. CARF has formed a 'specialized'—i.e. relatively industry specific—governance 'assemblage' or 'infrastructure', which spans the traditional boundaries of the nation-state, yet is connected and incorporated into local/national institutions (see Salter & Salter, 1997; Sassen, 2008). At the same time it could be

argued that based on the scope of CARF's international market, as a component of their overall business, the discourse and image of 'international-ism' for CARF is more significant than the current reality of their operations.

Program evaluation (program monitoring; performance monitoring/measurement)

As outlined throughout the historical overview of CARF, standards related to program or performance evaluation (also referred to as 'performance monitoring/'measurement') have been quite important as well as disputed throughout the history of CARF. Originally developed in the mid-70s, program evaluation is considered "one of the hallmarks of CARF" (Participant 4). At that time, one interview participant described CARF's standards on program evaluation, as having very specific parameters, whereby it didn't tell you exactly what measures you had to have, "but it did say you have to have an effectiveness, efficiency, and satisfaction measure in each program" (Participant 4). However another interview participant stated: "it was so statistical, so elaborate in its detail around the math that so many community organizations had a difficult time understanding what it was for" (Participant 6). Overall the program evaluation standards were somewhat detailed in proscribing the practices (administrative and service-oriented) for the organizations.

In the 1990s, under the leadership of Dr. Donald Galvin, CARF's standards for program evaluation were significantly scaled back, whereby "it was difficult to tell if people were meeting the standards or not, because it was so loose" (Participant 4). This was partly as a result of the shift in approach incited by Madeline Will in the vocational rehabilitation sector in the late 80s, whose entire philosophy was "we will pay you on

outcomes", but the processes and approach to getting there should be left up to the agency or facility (Participant 6).

Currently, the standards are somewhat more structured, and CARF is still looking to strike the right balance regarding program evaluation standards (Participant 3; Participant 6). However several interview participants raised concerns with the current framing of these standards. One problem is that the flexibility for agencies to define their own indicators to evaluate performance in some cases leads to a 'race to the bottom', especially as agencies continue to face increasing competition for funding and pressure for output.

"You have programs right now that measure their results by looking at once a person has gone through their program successfully then they start counting as to whether or not something happens to them. Do they get substance free, do they get hospitalized, do they get involved in the criminal justice system, or do they get a job? And getting a job is probably the most important of those in some respects, because people will go to a program to get a job. And you've got all of these things that have to be taken care of but the basic thing is to get a job. Well they will look at whether or not somebody successfully completes the program, and then they will start counting whether or not the number that successfully complete, after that they are in a cohort of looking at how many of those people got jobs. Our perspective when I was there was that once you say hello to them, they're yours, you've got a responsibility. That's much different; it's a much more demanding system because the numbers aren't going to be as great, when you have to count from that point. But when you don't say anything about it, and you let the organization decide how it's going to do it, then, if you believe in the integrity of once you say hello to them they're yours, and you want to look at your outcomes by that, how do you compete with somebody that says we're not even going to start looking until they have successfully completed our program. Some organizations, they don't want you to tell them how to do something, but what those standards did was to give surveyors a more common frame of reference to make their assessment of that aspect of the program. Absent that, each one kind of deals with it, whatever their level of knowledge and expectation is" (Participant 2).

At the same time, according to another interview participant, aside from the increase in flexibility of the program evaluation standards, the CARF standards in general are still criticized for their rigidity, and prescriptive business/administrative focus:

"Many organizations that are small, want to do something new...they are faced with trying...to meet those high level business requirements...Although fifty years ago that was correct, because there was no other alternatives for

good guidance and business practices of organizations, that has become a very difficult stumbling block for new creativity, like parents and families that want to set up some sort of co-op, or other innovative business designs, they're locked in to the business standards of accreditation that are overwhelming in cost and sophistication" (Participant 6).

In this way, while accreditation has consistently been marketed as an accountability strategy (see Galvin, 1999), standards and accreditation, from the perspective of some communities and service providers, are increasingly viewed as redundant and a limitation on innovation: "now the world is looking at them as almost duplicity...as now there is all this other due diligence around the money and reporting" (Participant 6).

The relationship between meeting accreditation standards and the outcomes or results has been a consistent concern in the field of accreditation for as standards have been in existence in health, social and human services (see Bowman, 1970, p. 51-60). As described by Worthen, Sanders and Fitzpatrick in 1997 (p. 123), "many accreditation bodies now also include standards related to outcome evaluation and attempt to link process to outcome through empirical research". At the same time Brommel's 2006 study on the Council on Accreditation (COA) also concluded that there remains a lack of evidence on the relationship between meeting standards and outcomes (p. 260). At the same time, the debate surrounding program evaluation by CARF adds a degree of complexity to the "normative framework" of accountability described by Brunet-Jailly & Martin (2010, p. 21).

While the research included in this major paper does not focus on CARF's standards and/or the program evaluation, these concerns are echoed throughout the literature, and continue to be an important issue facing all accrediting institutions. At the same time, the concerns raised through this research are important to note. First, as the flexibility of program evaluation standards are criticized for the potential misuse or 'favorable framing' of performance indicators by service providers, this

issues is also a product of the highly competitive market facing service providers (see: Newman & Clarke, 2009). Whatever the motivation, service providers are under continuous pressure to provide better results for less money, or risk losing funding and/or clients. Concurrently, the constraint of heavy administrative and business management standards, is also limiting innovation in the field as well as diversity of service providers, as the standards are more compatible with larger, more administratively sophisticated organizations (see: Miller, 1998; Barzelay, 2001; Newman & Clarke, 2009).

SUMMARY OF KEY FINDINGS AND CONCLUDING REMARKS

This Major Paper describes the historical evolution of a prominent accreditation body in the field of social/human services and rehabilitation, the Commission on Accreditation of Rehabilitation Facilities (CARF-International). I have demonstrated the growth of CARF, from its roots as a small organization founded by two facilities organizations in the mid-1960s, to a large, international organization, whose accreditation has been incorporated into government regulation through 'mandates' and recognition in many states in the United States, the U.S. Federal government, and by several Canadian provinces.

I have framed this historical analysis of CARF within the literature on accreditation and accrediting institutions, as well as select literature on the welfare state, governance, and transnational private regulatory standards institutions. As a result of this analysis, several key themes emerge.

First, in relation to the initial purposes/influences for developing standards and accreditation, the CARF example contrasts with the

existing research on the emergence of accrediting institutions in social and human services. In the case of CARF, the Director of the U.S. Federal Vocational Rehabilitation Administration (Ms. Mary Switzer) had a 'visionary' role in developing private accreditation, whereby in the other cases cited in the literature the main impetus and resources came from within professional groups. In this way CARF emerged as an example of the U.S. government engaging the private sector to develop mechanisms for quality assurance and accountability.

This relates directly to the second key theme, which looks at accreditation as a form of private regulation. While CARF emerged through the intention of the U.S. Federal government to develop private accreditation, its incorporation into regulation has been largely reliant on state mandates or recognition. CARF accreditation now has been recognized or mandated in numerous states and provinces, as well as several U.S. federal agencies. This has important theoretical implications, as it coincides with much of the literature on transnational private regulation (TPR) and governance, which counters more simplistic theories of 'privatization' and proposes that the very nature of 'the state' should be reconsidered to understand the embedded-ness of private actors or institutions in governance infrastructure/assemblages.

The third key theme looks at the governance structure of CARF, and highlights the change from a 50+ member Board of Trustees, with representation by a wide range of actors and institutions from the field, to an 11-member Board of Directors, with much limited input from the field in terms of CARF's governance. This change coincides with broader trends in adopting business practices in non-profit governance, by striving for efficiency and increasing the role of the CEO (see Barzelay, 2001; Newman & Clarke, 2009).

More so, the new governance structure of CARF raises important questions. Within the previous structure, the CARF Board of Trustees was a forum for debate and contestation between different interest groups involved in the field. In this way the practices and objectives of CARF were a reflection of the actors and interest groups involved. However under the new governance structure, it is much less clear what the driving goals and priorities of the organization will be. The implication of this shift is that the composition of CARF as a private accrediting institution has changed, while the power and influence of the organization remains. Therefore this is an area that merits further research in order to understand the implications for theory and practice/policy.

The fourth key theme is the role of CARF as a forum of debate between two main philosophical 'camps' within the health and human/social service sector. While many of the accrediting institutions in social and human services have emerged from one 'camp' or the other, CARF held a somewhat unique position through the involvement of both groups. The accreditation standards are still developed through an elaborate consultative process, however as the Board of Trustees no longer acts as a forum of debate and accountability between these two contrasting ideological approaches, the implications of this shift have yet to be seen.

The fifth key theme is the heightening growth in competition between accrediting bodies. This has emerged through a combination of factors including the multiplication of accrediting bodies competing for a 'market' that is expanding much less rapidly. At the same time, the impetus for growth within CARF (and likely other accrediting bodies) has also increased substantially through the adoption of market logic and ideology in the non-profit sector. In relation to CARF's governance

restructuring, it can be speculated that growth is now a driving objective of the organization.

The implications of prioritizing growth and increasing competition on CARF, as well as other accrediting institutions, is unclear, however it does reflect a shift in the intended purpose of the institutions. Based on CARF's move towards developing new products outside of accreditation (i.e. the financial reports for Aging Services), the practices that have defined CARF as an institution are changing to adapt to these new priorities and constraints. In this way the very definition of an accrediting institution should be queried.

The sixth key theme is the concept of 'international'. In comparison to much of the literature on transnational private regulation and governance, the current reality is that while CARF does have some international reach (specifically in the Canadian market) it is still quite limited, as a component of their overall business. The discourse of 'internationalism' has however been central to the framing of CARF standards as 'universal best practices', and thus technical and apolitical. However CARF and the CARF standards are rooted in the actors, institutions, research and ideology of North America, and therefore the 'international' framing is somewhat misleading.

The seventh key theme is the standards related to program evaluation (also called 'performance evaluation' or 'performance monitoring/measurement'). The concerns raised under this topic have important implications for policy and practice. As described by numerous interview participants, standards for program or performance evaluation rest within a tension. On one hand, when overly rigid, it limits innovation and/or diversity in terms of service-delivery practices and organizational management (i.e. favoring larger, administratively-advanced organizations or businesses).

On the other hand, when the standards are overly flexible—especially given the pressures on organizations to compete for funding and produce tangible, measurable results—it creates an environment where service providers have an incentive to mold their program evaluation practices in a way that favor reporting optics over substance. As a result, while individual service providers may be reporting positive outcomes of their services, the overall service system may be negatively impacted, as service providers ‘cherry pick’ clients, or fail to report important statistics, such as program completion rates. More so, the question was also raised of whether accreditation is a redundant layer of accountability and reporting, based on the high-level of oversight already established in North America. This theme coincides with an important question from the literature on accreditation – whether accreditation and standards lead to better services?

In relation to service system for street-involved youth in Vancouver, BC, the outcomes of this research raise important points for future interrogation. Firstly, based on the current standards, specifically around program evaluation, the question of how these standards have impacted the service delivery system in Vancouver merits exploration. Specifically – have accreditation requirements at the Ministry of Children and Family Development (MCFD) produced either of the concerns around limiting innovation and favoring large, more business- (or administrative) oriented organizations, or contributing to an environment where providers frame their program evaluating practices in a way that misses important information on the broader impact of the system? Secondly, based on the recent changes in governance at CARF, as well as the expanding pressures of competition and growth imperative, the question should be raised of how the changing practices, objectives, and ideology of CARF will impact local service providers and service delivery systems.

Another important point for future research that has been left unexplored within this paper is the expansion of CARF into the aging services sector, and specifically the development of new products—such as financial reports—that are beyond the previous scope of standards and accreditation that CARF has pursued. Quality assurance and accountability in the aging services field is currently a highly controversial area of research and policy (see Thomas, 2014, August 24), therefore the role of CARF within the sector is an interesting point for further inquiry.

Overall, this Major Paper has achieved the described purpose of the historical analysis of CARF – to provide a window into the broader field of accreditation in social and human services, and to highlight key themes related to theory, policy, and practice, and recommendations for future research.

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