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SPECIAL

Report

Accreditation as an Accountability strategy

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Introduction

This paper will address the role of national accreditation and its contribution to quality improvement and accountability in rehabilitation. The fundamental premise of this paper is the proposition that accreditation can be a powerful tool for achieving quality in the management of accountable rehabilitation

organizations, including quality in the services and supports provided and in the outcomes achieved. Accordingly, accreditation is not an end in itself; rather it is a means to achieve accountability and quality improvement in both management and service delivery.

Following a brief discussion of accountability within the context of accreditation, this paper will proceed to discuss the historical, social, economic, and policy dynamics which impact the accreditation environment. Some of the universal principles, values, and purposes which are at the heart of standards and the accreditation process will be reviewed, followed by a discussion of major trends in accreditation which are being fueled by changes in the organization, delivery, and financing of rehabilitation, health care, and other human services.

INSIDE *this* REPORT

We are pleased to reprint a paper, "Accreditation as an Accountability Strategy," which was presented by CARF President and CEO Donald E. Galvin, Ph.D., at the 20th Mary E. Switzer Memorial Seminar, sponsored by the National Rehabilitation Association. Titled "Accountability from Several Perspectives," the seminar was held at Michigan State University on September 24-26, 1998.

I. Accountability within the context of accreditation

Accountability basically means being responsible for something. In the context of health and rehabilitation, the individual consumer holds a variety of entities accountable. The individual consumer holds his/her employer accountable for purchasing health insurance plans that provide access to needed services. The individual consumer also holds various public and nonprofit agencies responsible for assuring that providers of health care and rehabilitation are accountable for delivering good care. And, finally, the individual consumer holds the health and rehabilitation professional accountable for his/her performance.

Dennis S. O'Leary, M.D., President of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), states:

In this scheme, the accreditation body is, in essence, a friend of the court. It is the neutral evaluator, which must do a good job, because its continued existence is determined by the reliance of others upon it. So the accrediting body is also an integral of the accountability equation. (May/June, 1997)

Sean Sullivan, President of the National Business Coalition on Health, defines accountability as being responsible for those things over which one has control and a willingness to submit to measures and to explain and communicate results. (1997) From this definition, one may conjecture that the rehabilitation organization may be held accountable for:

- Managing the delivery of care.
- Achieving improved life status among individuals being served.
- Delivering services at a reasonable cost.
- Measuring results.
- Communicating results.

Much along the same lines, Charles G.

Ray, Chief Executive Officer of the National Council for Community Behavioral Healthcare, notes that accountability — along with effectiveness, equity, and citizen participation — is at the core of the public debate on health care reform. (1996) In addressing accountability, Ray observes:

When we are taking tax and public dollars and we are using those dollars to provide care, it is the public's right to have accountability. The public deserves to know how many of those dollars are going to serve human beings and what is a realistic return on investment.

In conclusion, and as noted by Dr. O'Leary, systems of quality assurance, such as accreditation bodies, must also themselves be accountable. Accreditation bodies are accountable to the consumers who receive services from accredited organizations; they are accountable to the purchasers who typically are guided by accreditation in their purchasing decisions; they are also accountable to the provider organizations to assure that a high quality professional accreditation is in place. However, first and foremost, the accreditation body is accountable to the public at-large for rendering professional judgments for the protection of the public. Thus, in the largest sense, the accrediting body acts in the public interest to set standards of practice in a field, to evaluate conformance to those standards by organizations in the field, and to communicate that information to interested parties.

A bit of history and an acknowledgment

The setting of health and safety standards in the workplace, in public buildings, and among consumer products and professional services was a gradual development over the first half of the 20th century. The social reform, progressive, and professionalization movements early in the century set the stage for the setting of standards, the initiation of regulatory activities by various governmental entities, and — among professional groups — the development of accreditation mechanisms to identify those organizations

which met the standards as independently established by the field.

In the United States the public protection role of basic health and safety was largely assumed by government (e.g., food, drugs, mining, air transportation). The quality assurance role, however, has largely been the responsibility of the private sector via various professional trade groups and associations. The history of the Joint Commission on Accreditation of Healthcare Organizations provides an instructive example.

The American College of Surgeons (ACS) was organized in November of 1912 in an attempt to standardize and organize the practice of surgery. Stimulated by the rapid growth in the number of hospitals established between 1873 and 1909, the ACS adopted a resolution calling for "some system of standardization of hospital work." In 1916 the ACS received a grant from the Carnegie Foundation to develop hospital standards. ACS approached the task by conducting a nationwide survey of hospitals. The results were dismal!

As reported by Timothy Jost in the *Boston College Law Review* (July, 1983):

Of the 671 facilities of over 100 beds surveyed by the American College of Surgeons, only 89 could comply with the requirements. To avoid embarrassment to the prominent hospitals that had failed the standard examination, the list of approved hospitals was burned the night before its scheduled presentation in October 1919.

The growing complexity of hospital care and the growth of the industry quickly overwhelmed the resources of the Hospital Standardization Program which had been established by the American College of Surgeons in the early 1920s.

Following a period of strife and threats to develop separate programs, the American Hospital Association, the American College of Surgeons, the American Medical Association, and the American College of Pathologists agreed to form a "joint commission" for the accreditation of hospitals. The Joint Commission on the Accreditation of Hospitals (JCAH) held its

first organizational meeting on December 16, 1951.

With the advent of Medicare in 1965, JCAH was radically changed from a private, voluntary accrediting program to an agency with a major role in public health care regulation and financing. The Medicare bill permitted the Secretary of Health, Education, and Welfare (HEW) to grant "deemed status" to those health care providers to the extent that the Secretary found national accreditation bodies provided reasonable assurances that conditions of participation would be met. That is, such

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accredited hospitals, nursing homes, and home health agencies would be deemed to meet the quality requirements of Medicare participation. The Medicare statute, as finally enacted, not only required HEW to accept JCAH accreditation as a conclusive determination of hospital quality for participation in Medicare, but prohibited HEW from promulgating standards which exceeded those adopted by JCAH. In sum, the effect of the law was to deny Medicare reimbursement to hospitals that were not accredited by JCAH, and furthermore, assured that the government would not compete with, or trump, JCAH accreditation.

And in rehabilitation

The key individual responsible for the establishment of a national accreditation system in rehabilitation was none other than Mary E. Switzer, the first administrator of the Social and Rehabilitation Service, who is honored by this Memorial Seminar. During her remarkable tenure as the first Commissioner of the Vocational Rehabilitation Administration (now the Rehabilitation Services Administration), Ms. Switzer aggressively advocated for the establishment of national standards and an accreditation mechanism for the field of rehabilitation. She urged the two major professional associations in the field — the Association of Rehabilitation Centers (ARC) and the National Association of Sheltered Workshops and Homebound Programs (NASWHP) — to come together to establish a common set of standards.

In her typically shrewd and masterful administrative style, Ms. Switzer made it known that if the two organizations could not come together to develop an independent, peer-review-based private sector solution, she was prepared to initiate government standards and requirements. By way of incentive, she also made it known that she was prepared to provide grant funds to facilitate the establishment of such an accreditation system.

In 1966, with funding from the Vocational Rehabilitation Administration, the ARC and NASWHP formed the Commission on Accreditation of

Rehabilitation Facilities — now known as CARF ... The Rehabilitation Accreditation Commission. In addition to ARC and NASWHP, early organizational members of the Commission included Goodwill Industries of America (currently Goodwill Industries International, Inc.) and the National Easter Seal Society for Crippled Children and Adults (currently National Easter Seal Society). Most significantly, during the 1970s and 1980s approximately forty state vocational rehabilitation agencies adopted policies urging or mandating CARF accreditation for organizations serving state agency clients.

These two examples illustrate several common elements — including the leadership role played by professional groups — in the establishment of standards and accreditation processes, the collaboration and interdependence of the private and public sectors which are common in our form of government, and the critical role of reimbursement as a tangible incentive to promote participation and compliance.

Accountability as rediscovered in the 1990s

Although accountability as an expression of responsibility is not a new initiative, it is fair to say that it is a powerful concept which has been recently rediscovered — reinvented, if you will — and is now widely accepted in both the public and private sectors. Accrediting bodies have an ultimate social compact to protect and provide reassurance to the public as regards the quality of care being provided. For example:

- The mission of the Joint Commission is to improve the quality of care provided to the public through an accreditation process that promotes continuous improvement in organization performance. Quality improvement is the principal output of the accreditation process. (May/June, 1997)
- The National Committee for Quality Assurance (NCQA), the accrediting body for health care plans and managed care organizations, speaks of their mission in terms of enabling managed care accountability, driving quality improvement, and providing infor-

mation on quality to the marketplace, specifically employers and consumers. (NCQA, 1998)

- CARF ... The Rehabilitation Accreditation Commission cites as its mission, "... to serve as the preeminent standards-setting and accrediting body, promoting and advocating for the delivery of quality rehabilitation services." In addition, CARF's first stated purpose is, "To improve the quality of the services delivered to people with disabilities and others in need of rehabilitation." (1998)

II. The accreditation environment

The social, economic, and political dynamics that impact provider organizations in turn impact their accrediting bodies and their accreditation standards. That is, as the public policy agenda begins to address issues of the organization, delivery, financing, and quality of health and rehabilitation services, the impact upon providers and their accrediting bodies is undeniable. In truth, standards are steadfast, but not static. The accreditation process and standards evolve over time to remain relevant to the state of the art of service delivery and to be responsive to — and even reflective of — the concerns, values, and concepts of each era or generation of human services. To cite only a few recent influences, note for example: the devolution of governmental authority to the states; the consumer movement including, specifically, disability rights; and the profound influence of the purchaser of health and rehabilitation services illustrated most dramatically in this era of managed care.

As emphasized, the accrediting bodies in a very real sense are derivatives of the field or industry that they are to monitor. While accreditors must stand independently, they cannot be aloof; for if they take a

detached posture, they risk becoming seen as irrelevant. Indeed, if one were to systematically review the standards manuals of a human service accrediting body, one could clearly trace the cogent concepts and values of the time. In rehabilitation, for example, one could detect a movement from a near exclusive focus upon the professional provider to today's emphasis upon consumer participation and choice; from an emphasis upon organizational structure and process to a growing emphasis upon outcomes or performance; from a near "black box" mentality which held the details of the accreditation experience to be confidential to more interest in public information and open communications (note the President's recently proposed Consumer Bill of Rights as recommended by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, 1997).

Among the social, economic, and political forces impacting the providers, consumers, and purchasers of rehabilitation services and supports, one can identify:

- **The Americans with Disabilities Act which holds all of our society accountable for access and opportunity.**
 - **The Rehabilitation Amendments of 1992 which emphasize consumer choice, empowerment, and participation in community life.**
 - **The various state and federal initiatives to reform and regulate health care delivery with special attention to managed care.**
- These public policy measures emphasize access to health care and information about health plans and providers. They also call for greater consumer participation in treatment decisions and often provide a mechanism for filing grievances and appeals.
- **The impact of the consumer movement across society with special reference to the disability rights movement.**

As consumers we now want to know more about the products we buy. In this day, who would purchase a new car, computer, or washing machine without

first consulting Consumer Report? We also want to assess the universities and hospitals we turn to for education and health care (note the popularity of the ratings of such institutions in the recent issues of U.S. News and World Report). In rehabilitation the disability rights and independent living movements were in large measure a reflection of the social impetus for civil rights and consumer empowerment, choice, and participation.

- **The ubiquitous computer as a tangible manifestation of the Information Age.**

While we may often feel overwhelmed with information, we have come to appreciate that we now have access to data and information which can enhance management, aid in analysis and assessment, and accelerate the decision-making process. The current focus upon outcomes and performance measurement is a direct by-product of this new found capability.

- **The Total Quality Management (TQM) theology with its emphasis on data, continuous improvement, and consumer satisfaction.**

With TQM principles highlighting the theme of maximizing quality while reducing costs, this movement has swept throughout all sectors of the economy. In health care and rehabilitation, providers suddenly must discover a way to determine exactly what the person served needs, and the essential necessary service components, while at the same time maintaining or even enhancing the quality of care. In other words, achieve outcomes with tailored and essential processes. (Wilkerson, 1997)

- **Marketplace dynamics — particularly the enhanced role of the purchaser of health care and rehabilitation services — as the overriding relevant economic theme of the 1990s.**

As a society, we have reaffirmed our belief that product and service quality is best enhanced through competition and attention to customer satisfaction.

To draw upon an earlier theme, information, including information derived from accreditation and quality measurement, is absolutely essential in a competitive marketplace. Survival in such a marketplace depends in large measure upon an organization's ability to know its customers, its processes, its costs, and its outcomes. Over the last few years, both public and private purchasers of health and rehabilitation services have come to view and treat providers of such care as any other supplier of goods and services.

The spectacular growth of managed care in recent years is a direct testimony to the influence of a marketplace driven by the power of the purchasers in terms of: the individual to be served; the services to be provided; and the providers to be utilized. This new paradigm has understandably caused much anxiety, concern, and confusion among both providers and consumers of health and rehabilitation services. In their zeal to achieve greater control over the provision of services, purchasers have emphasized provider credentials. That is, many managed care organizations will include in their panel of providers only individuals and organizations which have been properly licensed, certified, and/or accredited. This is done in the spirit of exercising "due diligence" in protection of their members and serves as a low cost quality control mechanism. While the final decision as to selecting and utilizing a provider may be largely driven by costs and — to a growing degree — performance, the credentialing requirement essentially says to providers, "Unless you have the requisite credentials, we will not consider utilizing your services." Of course, in much the same way, public purchasers such as vocational rehabilitation, mental health, developmental disabilities, and workers compensation agencies adopted the same policy and practice years ago when they required individual certification and organizational accreditation before the public agency would refer clients to the provider.

By way of summary, it may be concluded that rehabilitation providers will be confronted with the challenge of implementing strategies to address the

demands of the consumer-focused, outcomes-oriented, payer-driven environment of the 21st century. As delivery systems are restructured and as efficiencies and cost containment are pursued, it will be all the more essential to demonstrate that quality and accountability have not been compromised. Accreditation as the “quality advocate” has an essential role to play in such an emerging environment.

A recent conference sponsored by The Institute on Disability and Managed Care of the United Cerebral Palsy Associations, Inc., entitled, “Managing the Winds of Change,” (1998) perhaps best describes the environment confronting providers, consumers, purchasers, and accreditors. The conference brochure opens with the query:

Is your organization working to get in sync with the customer, get costs down and quality up in a dynamic environment of devolution, performance contracting, and consumer self determination?

III. *The benefits of accreditation*

Accreditation makes diverse contributions to the field of rehabilitation practice and service delivery, to the consumers in search of qualified providers, and to those public and private purchasers of rehabilitation services.

In terms of the person served

The standards developed and promulgated by an accreditation body have the potential to translate and operationalize values, principles, and enlightened public policy into daily practice touching literally millions of individuals with disabilities. For example, through conformance to standards, the following concepts and values become

realities for persons served by rehabilitation organizations:

- The rehabilitation organization seeks, obtains, and uses input from persons served and other stakeholders.
- The rehabilitation organization engages in person-centered planning, design, and service delivery.
- The rehabilitation organization recognizes the rights of the person served and treats all persons served with dignity and respect.
- The rehabilitation organization makes a commitment to enhance the lives of the persons served as defined by the person served.
- The rehabilitation organization appreciates the value of diversity and is culturally competent in serving its clientele.
- The person served is an active participant in planning, selecting, and evaluating the services provided by the rehabilitation organization.
- The rehabilitation organization demonstrates a clear focus on its customers, its customers’ expectations, and the results of services provided in terms of the achievement of goals and customer satisfaction.
- The rehabilitation organization meets the requirements of the Americans with Disabilities Act.
- The rehabilitation organization acts as an advocate for access to care for people with disabilities and for the removal of architectural, attitudinal, communication, employment, and other barriers to people with disabilities.

Lastly, accreditation offers confidence to consumers that an independent review process is in place specifically focused on improving the quality of the rehabilitation services they receive.

In terms of the management of rehabilitation organizations

Most accrediting bodies have standards that address the organization and management of provider organizations. These standards, for many rehabilitation administrators, provide their first exposure to management

principles — a kind of “Management 101” for individuals who have been trained as counselors, psychologists, social workers, and therapists. Organization and management standards commonly address:

- Governance.
- Strategic planning.
- Financial management.
- Information systems.
- Outcomes measurement and management.
- Human resources.
- Health and safety.

Such standards provide an accepted blueprint for efficient and effective operations, a quality improvement strategy, and a management tool to continually evaluate and improve services and programs. It should also be noted that consumers and family members frequently have concerns regarding the survivability of the provider organization. Parents of a young person with a disability being served by a community rehabilitation organization want assurance that the organization is well run, solvent, and will be there to provide services and supports over many years.

In terms of recognition

Accreditation identifies to consumers, providers, purchasers, public officials, and the general public those organizations that meet recognized standards. In terms of the marketplace dynamics cited earlier, such recognition has become increasingly essential. As Cheryl Murer, J.D., has written, “Purchasers are telling individual provider organizations that performance evaluation begins with accreditation. Accreditation is a ticket to play.” (1997) Further, and as noted above, in consideration of their due diligence responsibilities, purchasers are not likely to assume the unnecessary risk of utilizing providers who do not achieve accreditation, the first level of quality assurance.

Purchasers also recognize the public relations value of adopting a policy that declares, “We only purchase services for our employees, subscribers, or clients from organizations that are nationally accredited.”

Recognition takes many forms. For example, Standard and Poors (S & P) has

begun to rate human service providers. In their April 1994 report, S & P states:

Accreditation, where appropriate, by national bodies such as the Commission on the Accreditation of Rehabilitation Facilities (CARF) serve as indicators of compliance with professional standards [sic].

They advised that such an indicator of provider professionalism, along with funding history and market share, impact the financial ratings of quasi-governmental providers and freestanding nonprofit community agencies.

In a report to the author, the Kresge Foundation of Troy, Michigan, reported on a survey they had conducted dealing with grant-making to human service organizations. Respondents to the survey had advised that grants should only be made to agencies that had achieved national accreditation, “... because it is an indicator that the agency is concerned with quality and it improves their credibility and reputation in the community.” (1994)

In terms of the government

As noted earlier, the public sector — including the federal government, states, counties, and municipalities — often establishes interrelationships with independent accrediting bodies, sharing responsibilities — and accountability — for human service quality assurance. The term “deemed status” is used to mean that, via national accreditation, the provider organization is “deemed” to have met the public agencies’ regulatory requirements. Such arrangements are attractive to governments for at least three reasons.

1. They demonstrate public-private partnerships, sharing of responsibilities and authority, and a pluralistic approach to monitoring and oversight.
2. The use of an external accrediting body with its established criteria, standards, and independent reviewers relieves the government of charges that the state funding agency is biased or politically motivated in the award of contracts or the referral of clients. This goes directly to the issue of conflict of interest.

3. And finally, the use of an external accrediting body relieves the public agency of some of the costs of employing its own reviewers. It is not uncommon for a large state which does not utilize accreditation to employ hundreds of state employees to engage in periodic visits to provider organizations.

IV. Accreditation ... some basic principles

To provide assurance that services and supports are being effectively monitored and evaluated and are being held to high performance expectations, national accreditation bodies share many common principles and approaches. These principles have evolved over the years and reflect the purposes, values, and vision of the accreditation organization. The typical national accreditation body engages in:

- The development and maintenance of state-of-the-art standards that provider organizations can use to assess and improve the quality of their programs. The standards are often performance-based and consumer-focused and address key processes that providers must utilize to produce good outcomes.
- The inclusion of various stakeholders — including consumers, providers, and purchasers — in the governance of the accreditation body and in the development of standards.
- The provision of independent, impartial, experienced, and qualified peer reviewers as surveyors.
- The application of standards in periodic on-site visits where services are actually delivered.
- The provision of suggestions and consultations during the site survey along with the application of standards

and evaluation of the organization's policies, processes, and performance.

- The provision of a survey report following the site visit with observations, commendations, suggestions, and recommendations to improve conformance to standards where the organization has demonstrated deficiencies.
- The requirement that the provider organization prepare and submit a quality improvement plan to address program deficiencies as identified in the survey report.

V. Trends in accreditation

Accreditation standards and processes should be faithful to legislation and public policies, informed by state-of-the-art professional practices, and driven by the quality and accountability imperative. The quality imperative is also expressed in terms of emphasizing continuous quality improvement in management and service delivery and in the recognized need to enhance performance measurement and management.

To fulfill their accountability mission, accreditors must also be growing, changing, and responsive to their environments. Accrediting bodies are themselves engaged in a competitive environment, their performance is scrutinized, and if they fail to deliver quality services or keep current with developments, they will lose customers and market share. To stay current, competitive, and responsive, there is a need to focus on the basic validity and reliability of the accreditation process.

There are several trends which can be identified in terms of the evolution of accreditation practices in response to new

developments and expectation. Among these trends, one may cite the following:

- **Outcomes measurement and management.**

As noted earlier, while standards typically address organizational structure and management and service delivery processes, there is growing emphasis upon the outcomes — results for persons served — and on the use of outcomes information in managing programs and enhancing service delivery.

Rehabilitation administrators, clinicians, and researchers have had a long-standing interest in results, benefits, and the impact of services provided to persons with disabilities. For over twenty years CARF has required that providers evaluate their programs in terms of effectiveness, efficiencies, and customer/consumer satisfaction. JCAHO has introduced the ORYX system which requires health care providers to utilize approved outcomes measurement systems, while NCQA has created the HEDIS system requiring health care plans to report specific data on approximately thirty health care interventions (i.e., childhood immunization, breast cancer screening, follow-up after hospitalization for mental illness, member satisfaction, etc.).

- **Performance indicators.**

Dennis O'Leary, M.D., President of JCAHO, states, "The use of performance indicators will first of all change the focus of attention from compliance to standards to actual results." (September/October, 1996).

In this age when public and private purchasers are shifting from "buying programs" to "buying results," it is imperative that performance-oriented indicator systems be developed. Sean Sullivan (1997), of the National Business Coalition on Health, advises that providers and purchasers need to agree on indicators that are credibly reliable. He emphasizes that purchasers are moving from a "buy and measure" approach to one of "measure and buy."

Purchasers are clearly looking for those providers who are willing to both submit to measurement and communicate their results.

Performance indicators address the essential question, "What does a stakeholder want to know about a program's performance in order to assess its quality and to choose among providers?" To be reliable and valid, however, there must be agreement among stakeholders as to the essential indicators to be measured. In order to achieve legitimate "apples-to-apples" comparisons, several technical concerns must be addressed including measurement approaches, risk adjustment, and uniformity of reports.

Rehabilitation Continuum Report (July, 1998) asked a group of experts in medical rehabilitation to name the most important indicators that should be tracked. They reported the following:

- Discharge rate to the community.
 - Productivity of the individuals served (work, school, family role).
 - Durability of outcome.
 - Improvement in functional independence and performance of typical activities of daily living.
 - Length of stay.
 - Value of outcomes (cost of care versus the outcomes achieved).
- **Public information.**

Until recently, the results of the accreditation site visit and survey report were considered to be confidential information between the provider organization and the accreditor. Typically the accreditation body would only report the provider organization's accreditation status and the duration of the accreditation award.

In response to the demands of the general public, consumers, and purchasers, most accreditors have begun to alter their information dissemination policies. Some even post the survey report or a summary of the report and scores on the Internet. The press for more information on provider performance addresses the trends toward consumer empowerment and choice

which are vital considerations in rehabilitation and among the general public. Cheryl Murer states, "The baby boomers are having a major impact on accrediting bodies with their demand for disclosure." (1997)

According to a report in *The Journal of the American Medical Association* (1997), reports to consumers that rate the quality of care delivered by hospitals and other health care providers not only help patients and families make informed decisions, but also spur improvement in the care provided. The study, which surveyed changes in services offered to obstetric patients in 82 Missouri hospitals, found that 50 percent of hospitals had either improved their practices or planned to do so within one year of release of a report to consumers.

Daniel R. Long, M.D., Associate Professor of Medicine at the University of Missouri, stated:

But not only do we find that consumers read these reports, but providers — physicians and hospitals — read these reports. In our study, we found that providers took the reports seriously, looked at how they compared with one another, and they made necessary changes in the nature and type and quality of services they provide to pregnant women and infants.

VI. Conclusion

Accreditation bodies want to provide a value-added service — one that provides a quality guide for provider organizations, a signal of quality to consumers and purchasers, and assurance to the public that accredited health and rehabilitation organizations are accountable and should be supported. Such added value applies equally to the accountability of the field to persons served and the accountability of the accrediting body to the public at large.

Accreditation should not be viewed as an end in itself, but should serve as an opportunity to reinvigorate, to redesign, and to engage in system change while enhancing the organization's development and capacity to accommodate and succeed in its ever-changing and challenging environment. It is no longer a cliché to state that we are in the vortex of substantial, pervasive change — change in the relationship between government and the individual; change between the federal government and the states; change between the public and private sectors; and change between providers of rehabilitation services and the consumers of those services.

In the face of such change and dislocation, national accreditation can serve as a common ground for provider organizations, consumers, families, purchasers, and the community. National accreditation can, in fact, provide partnerships, associations, forums for common interests, and a vestige of stability and standardization in the ever-changing rehabilitation environment. Seeking that critical balance between principled stability on the one hand and flexible, constructive response to the very real revolution in the organization, delivery, and financing of health and rehabilitation services on the other hand will no doubt continue to challenge the accreditors.

Notes

1. O'Leary, Dennis S. (May/June, 1997). Joint Commission Perspectives, p. 2. Joint Commission on Accreditation of Healthcare Organizations. Oakbrook Terrace, IL.
2. Sullivan, Sean (1997). Speech to National Medical Rehabilitation Conference. CARF ... The Rehabilitation Accreditation Commission. Tucson, AZ.
3. Ray, Charles G. (1996). In the Public Interest, p. 1. National Community Mental Healthcare Council. Bethesda, MD.
4. Jost, Timothy (July, 1983). The Joint Commission on Accreditation of Hospitals: Private Regulation on Health Care in the Public Interest. Boston College Law Review. pp. 847-850. Boston College, Boston, MA.
5. National Committee on Quality Assurance (1998). Presentation to Quality and Accountability Summit. Institute for Behavioral Health. San Antonio, TX.
6. CARF ... The Rehabilitation Accreditation Commission (1998). The Accreditation Sourcebook. Tucson, AZ.
7. President Clinton Endorses Consumer Bill of Rights and Calls for Immediate Action to Implement (November 20, 1997). White House Press Release. White Office: Office of the Press Secretary. Washington, DC.
8. Wilkerson, Deborah L. (August/September, 1997). Outcomes and Accreditation. Rehab Management. pp. 114-115. Marina del Rey, CA.
9. United Cerebral Palsy Associations, Inc. (August, 1998). Institute on Disability and Managed Care. Managing the Winds of Change. Conference Brochure. Washington, DC.
10. Murer, Cherilyn, J.D. (August/September, 1997). Certification and Accreditation. Rehab Management. Marina del Rey, CA.
11. Standard & Poors (April, 1994). S & P Begins Rating Human Service Providers. Creditweek Municipal. p. 2. New York, NY.
12. Personal Letter to Author (March 25, 1994). The Kresge Foundation. Troy, MI.
13. O'Leary, Dennis S. (September/October, 1996). Joint Commission Perspectives. p. 4. Joint Commission on Accreditation of Healthcare Organizations. Oakbrook Terrace, IL.
14. American Health Consultants (July, 1998). What Customers Want to Know About Your Program. Rehab Continuum Report. Vol. 7, No. 7. p. 87. Chicago, IL.
15. Reuters Health Information Services, Inc. (November, 1997). Rating Reports Change Hospital Care. The Journal of the American Medical Association. Yahoo News, Internet.

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