Accreditation 2000: The Journey Continues

by Kimberly A. Baldwin-Stried, MBA, RHIA, CPHQ, and Constantine V. Godellas, MD, FACS

What's in the future for healthcare accreditation? The roots of its future can be found in the present. Here's a look at where accreditation has been—and where it's going.

Accreditation: it's a fact of life for many healthcare organization employees. As we enter the 21st century, healthcare accreditation continues to respond to challenge and change. In this article, we'll look at an overview of this process—where it's been and where it's going—as well as some useful lessons learned for HIM professionals.

It Started with Codman

In its more than half-century existence, healthcare accreditation has evolved and changed almost as rapidly as technology. The initial concept that ultimately led to the development of today's accreditation processes was first proposed in 1910 by surgeon Ernest Codman, who believed that hospitals needed to establish a way to track every patient they treated "long enough to determine whether the treatment was effective."[1] After a few years' discussion and debate, another surgeon, Franklin Martin, adopted Codman's concept of "the end result of hospital standardization" and the American College of Surgeons (ACS) was founded.[2]

One ACS's primary objectives was to establish standardization among hospitals throughout the country and ultimately raise standards of surgery. By 1918, the group had developed a one-page Minimum Standards for Hospitals and began to survey hospitals throughout the country. Of the 692 hospitals surveyed in that year, only 89 met these "minimum standards."[3]

By 1950, the results of the ACS's accreditation program were evident. The standards of care had dramatically improved and more than 3,200 hospitals throughout the United States and Canada were accredited. In 1952, ACS joined forces with the American College of Physicians, the American Hospital Association, the American Medical Association, and the Canadian Medical Association to establish the Joint Commission on Accreditation of Hospitals (JCAH), an independent not-for-profit organization whose primary purpose would be to provide voluntary accreditation for hospitals.[4,5]

During the next decades, growth within the healthcare industry exploded, and so did the accreditation process. The Joint Commission was recognized as a leading expert in the assessment of hospital performance and compliance with standards.

Congress's 1965 passage of the Social Security Amendments added a reason for hospitals to be accredited. Accreditation by the Joint Commission was highly sought after because this stamp of approval meant the hospital met the standards for participation in the Medicare program and thus was eligible to receive federal and state funding (Medicare and Medicaid).[6] By 1985, the breadth and depth of the scope of the Joint Commission's services began to change even more dramatically. Where it had once primarily focused on evaluation of hospital-based quality of care standards and procedures, the group added several accreditation councils and expanded its services to include nonacute settings such as long term care, care for the mentally retarded and developmentally disabled, psychiatric and substance abuse facilities, ambulatory care, and home care.[7]

In 1987, the Joint Commission changed its name to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to more adequately reflect an expanded scope of service and activities. That same year, the organization introduced a new "Agenda for Change" philosophy, announcing that for the first time the accreditation survey process's emphasis and approach would change.

Rather than measuring a healthcare organization's ability to comply against a set of established standards, the Joint Commission shifted its emphasis to evaluation of the organization's ability to assess and improve its own performance. Rather than "inspect and detect" areas of noncompliance or nonconformance, the role of a surveyor changed to "consultant and educator."

Out with the Old, in with the New

Change is never easy. The Joint Commission's transition from a "less authoritative" to a "more consultative" role proved to be challenging for most healthcare organizations from about 1993 to 1996. Gradually, mindsets, systems, and procedures within both the Joint Commission and the healthcare organizations were changing. The process had some bumps—for example, some organizations complained that Joint Commission survey fees were becoming "cost prohibitive" while adding little in tangible value to the bottom line. And the process of transitioning from departmental standards and document review was difficult for many.

Healthcare organization preparation changed as well. Traditionally, an appointed Joint Commission liaison spent hours working with departmental managers in the review and scoring of hospital compliance against departmental standards. Policy and procedure manuals would be frantically reviewed and revised, sometimes up to the night before a survey, in hopes of avoiding a "comment or recommendation" from a surveyor.

Under the new and emerging Joint Commission accreditation process, old habits and routines had to die. The emphasis of the process was now on "process and collaboration."

Remember, the emphasis of the Joint Commission review had shifted from "assuring quality" to "improving performance." Hospital performance was no longer to be assessed by reviewing endless policy and procedure manuals. Instead, a surveyor would now assess an organization by observing systems and processes and by talking to those involved. Simply putting policies and procedures on paper, but not into actual practice, would not result in a favorable outcome. Hospital managers would have to find new ways to do things.

Coming a Long Way, Maybe?

The transitions of the mid-1990s may have been difficult, but quality management and Joint Commission liaisons interviewed for this article believe that the shift in emphasis from department-specific standards to interdisciplinary processes resulted in increased improvement in healthcare quality and patient satisfaction.

"The Joint Commission survey today is more relevant," says Deborah C. Beezley, RHIT, director of HIM at St. Anthony's Medical Center in St. Louis, MO, and a former Joint Commission employee. "Its focus on systems and processes encourages interdisciplinary teams of professionals to communicate and work together in data analysis and problem resolution."

A recent government report, however, indicates there is still room for improvement. "The External Review of Quality: A Call for Greater Accountability," published by the Department of Health and Human Services' Office of Inspector General (OIG) in July 1999, cites major deficiencies in today's external review and oversight systems.[8]

The study, the result of a two-year investigation of today's hospital oversight system, concluded that that the current Joint Commission survey methods "are unlikely to surface patterns, systems, or incidents of substandard care and are unlikely to identify practitioners whose judgment or skills to practice medicine are questionable."[9]

A summary of the OIG's significant comments offers insight as to what the government may require of accrediting agencies in the future. Significant recommendations include:[10]

- providing surveyors with more background information about the organization, such as media reports or complaints made by patients and families prior to each survey, or background information on organizational changes involving the hospital, rather than relying upon the hospital to self-disclose any major problems
- establishing a system and approach to hold the Joint Commission and state agencies more fully accountable to the Health Care Financing Administration (HCFA) for their performance in review of healthcare organizations
- joint determination of some of the year-to-year survey priorities of the Joint Commission. HCFA would work collaboratively with the Joint Commission to establish priorities for the hospital oversight reviews
- increasing the number of unannounced surveys or surprise inspections in response to complaints

- conducting greater numbers of reviews on randomly selected, current patient records
- establishing a means to conduct more rigorous assessments of the organizations' continuous quality improvement activities

Others outside the OIG have also called for change in the hospital oversight and accreditation process in recent years. Citing findings contained in separate reports on California and New York hospitals, California congressman Pete Stark lambasted the Joint Commission and lobbied to overhaul its hospital review process. "The misguided scoring and lax oversight documented in the New York and California reports suggests that another system of oversight is needed," Stark said in a press release.[11] As a result, he cosponsored two bills—the Accreditation Accountability Act of 1997 (HR 800) and the Medicare and Medicaid Review Act of 1997 (HR 2543). The first bill, HR 800, would have required all Medicare-accrediting organizations to hold public meetings, while the second, HR 2543, would levy user fees on hospitals and other healthcare providers to underwrite the costs of independent federal compliance audits.

What's Next?

Though it has its critics, today the Joint Commission is, by far, the dominant accrediting agency for hospitals and other healthcare organizations. Reviewing and accrediting nearly 19,500 healthcare organizations and programs in the US and worldwide, the Joint Commission emphasizes education and performance improvement and is leading the way toward a more "collegial mode of healthcare review" versus traditional "regulatory modes of review."[12,13,14] (See "Comparison of Modes of Healthcare Review.")

Comparison of Modes of Healthcare Review

Regulatory	Collegial	Evolving
• Challenging • Rigid • Enforce minimums • Directive • Skeptical • Public accountability • Public disclosure • Outlier focus • Minimize preventable harm • Emphasis on "investigate and enforce"	• Cooperative • Flexible • Foster process improvements • Guidance • Trusting • Professional accountability • Confidentiality • Systems foucs • Improve patient outcomes • Emphasis to "educate and elevate"	• Accountability • Public disclosure • Nonvoluntary minimum review cycle • Outcomes & performance measurement • Unannounced visits • Provider reivews • HCFA oversight • Automated data submission • Minimum standards • Balance and integration of collegial & regulatory modes

"Overall, the hospital review system is moving toward a collegial mode of oversight and away from a regulatory mode."

—Department of Health & Human Services, Office of Inspector General

The revised Conditions of Participation proposed by HCFA in December 1997 are indicative of the intent to encourage state agencies to adopt a more patient-centered approach to healthcare review.[15] HCFA hopes that instead of continually responding to complaints and adverse events, state agencies will follow the Joint Commission's lead and shift their emphasis away from adherence to strict rules and policies toward establishment of "data-driven performance improvement projects."[16]

Meanwhile, the government continues to keep an eye on healthcare quality. One notable group is the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, appointed in 1997. This 34-member group was chartered to "advise the President on changes occurring in the health care system and recommend measures as may be necessary to promote and assure health care quality and value, protect consumers and workers in the health care system."[17] The commission explores exactly who, what, and how quality is evaluated by health care organizations.

In "Strengthening the Market to Improve Quality, Promoting Accountability," a chapter of its final report released in July 1998, the commission addressed what it believed would be the roles of quality oversight/accrediting agencies in the future. This report and the 1999 OIG report both touch on the current significant shared beliefs about the future of healthcare accreditation.

For example, both reports compare and contrast the roles of state accrediting agencies against those of private-sector bodies. And both reports recommend the need for expanded healthcare accreditation/quality oversight activities, with enhanced emphasis on safeguarding patients, improving healthcare delivery, and greater accountability.

If there will be greater emphasis on review of healthcare organizations and providers in the future, then what effect will other accrediting agencies have in shaping the future of accreditation? The numerous private and state accrediting agencies in existence today vary widely in their scope of services and the approaches they take in performing their reviews. Some organizations directly compete with one another; others maintain a symbiotic relationship. Whatever role they play will be based in part on the philosophy of the accrediting organization and the numbers and types of healthcare organizations they serve.

"Accrediting Bodies in Action," summarizes some of today's most recognized accrediting bodies and the organizations/functions they review.

Accrediting Bodies in Action

Accrediting Body	**Reviewing**
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	Hospitals Behavioral health Home care Ambulatory care Clinical laboratories Long term care Managed care plans
National Committee for Quality Assurance (NCQA)	Managed care plans Managed behavioral health
American Accreditation Health Care Commission/Utilization Review Accreditation Commission (AAHCC/URAC)	Managed care plans
American Osteopathic Association	Osteopathic hospitals
Commission on Accreditation of Rehabilitation Facilities (CARF)	Rehabilitation hospitals
Community Health Accreditation Program of the National League of Nursing	Home care organizations
College of American Pathologists (CAP)	Clinical laboratories
American Association of Blood Banks (AABB)	Blood banks
American College of Surgeons (ACS)	Hospital cancer programs/tumor registries
Accreditation Association for Ambulatory Health Care (AAAHC)	Ambulatory care
American Medical Accreditation Program (AMAP)	Physicians

Because more than 80 percent of US hospitals, as well as the majority of today's other existing healthcare organizations, use the Joint Commission as their main surveyor, it is anticipated that the Joint Commission will continue to lead the way in the evolving healthcare accreditation process.[18]

Whether you believe that today's accreditation process is "new and improved," or fraught with problems and deficiencies, one fact remains. Healthcare accreditation has become a vital function in the evaluation of healthcare delivery in the United States and many other countries. Accreditation processes of all kinds will shape and redefine our healthcare system—not only now, but in the years to come.

Is Accreditation for Everyone?

While accreditation is an influential process, many healthcare organizations have asked themselves what value the process brings to them. In 1994, when the Joint Commission first increased its survey fees, many financially distressed, small, stand-alone hospitals or rural facilities seriously began to evaluate alternatives to accreditation. As a result, the percent of nonaccredited hospitals that have not been surveyed within the three-year industry standard grew from 28 percent in 1995 to 50 percent in 1997.[19]

"It can be very difficult for the small, rural provider to justify the costs of a survey," says Mike McManus, president of St. Clement Health Services, a 50-bed acute and long term care provider in Red Bud, IL. "I know that if we didn't have the support of our dual sponsors and access to greater financial resources because we're part of a regional healthcare system, it would be difficult for us to justify the kind of expense and time that goes into a survey."

And the costs continue to increase. Citing "continued inflation in the labor market, in travel and other vendor costs," Dennis O'Leary, president and chief executive officer of the Joint Commission, announced another 3.25 percent increase in survey fees effective January 1, 2000, raising the average cost for a full hospital survey in the year 2000 to approximately $20,650.20.[20] In an industry already overburdened with resource shortages, increased governmental scrutiny, and declining reimbursement and revenue streams, it won't be surprising if this trend in nonaccreditation continues.

Which organizations may choose to be nonaccredited? Most likely, hospitals located in rural areas or smaller stand-alone facilities with limited financial resources. Small, rural facilities may decide, for example, that the costs of a survey may be better spent through investments in technology or the community.

"The business of the rural healthcare provider is taking care of the community," McManus says. "And if you work collaboratively with your physicians and maintain the faith and trust of the community you serve, then your community is probably going to support you and your physicians, regardless of whether or not you are accredited by the Joint Commission." He adds, however, that he is thankful his facility can afford a survey despite the cost. "Accreditation has helped us improve our performance, and we learn a lot going through the process," McManus says.

Why Accreditation Is Important Now

The Joint Commission's processes continue to evolve. For example, as of January 1, 2000, it eliminated the "Accreditation with Commendation" category based on input from consumers, healthcare organizations, and others. The organization noted in a press release that eliminating this category was suggested by the OIG report.

This year, the Joint Commission will continue to work to make the emphasis of the accreditation process "more meaningful," as the OIG suggests, and to further develop measures to standardize the review process.[21] In many ways, the group will be toughening its standards. In August 1999, the Accreditation Committee of the Joint Commission Board of Commissioners approved significant revisions to aggregation and decision rules for 2000 surveys that will affect the way conditional accreditation—given to facilities that are not in substantial compliance and requiring a follow-up survey—is assigned. Effective January 1, 2000, conditional accreditation will be made for grid scores of less than 75; previously, conditional accreditation had been given for grid scores less then 50.[22]

"Surveys conducted in 2000 are going to be tougher and tighter," says Marcia Hargreaves, director of quality management/Joint Commission liaison for Rush-Presbyterian St. Luke's Medical Center in Chicago. "Provisions are in place for the organization to receive multiple Type I deficiencies in various categories. We are experiencing a raising of the bar—as healthcare professionals we are challenged to meet it."

Beezley agrees that the bar is rising. "This tightening of the 2000 survey process demonstrates the Joint Commission's commitment to addressing past concerns that the organization had become too customer focused and did not have adequate measures to review and respond to complaints," she says. "Their focus today, on the implementation of ORYX and the development of hospital core measures, shows they are making significant progress toward integration of outcomes and other performance measurement systems into the survey process and will ultimately have standardized measures to review performance."

The ORYX Initiative

First introduced in 1997, ORYX is a performance measurement initiative designed to integrate outcomes and other performance measurement systems into the Joint Commission accreditation process.[23] One of goals of this initiative was to establish a data-driven approach to the review of clinical care and ultimately improve the value of accreditation. Under ORYX, healthcare organizations are mandated to identify a minimum number of clinical measures for which clinical data is collected. The data is submitted to the Joint Commission under highly sensitive time frames.

Since its introduction, organizations have reported mixed success in implementation of ORYX. For example, one user reported confusion because "the data used to compute performance measures by the vendor is typically data that hospitals have forwarded to the State of Illinois Hospital Cost Containment Council (IHCCC) and from there to the Illinois Hospital and HealthSystems Association (IHHA). Due to IHCCC and IHHA data processing time lines, this data is not available to the vendor until long past the ORYX submission deadline."[24]

In the past year, some provisions were simplified. Effective in the second quarter of 1999, the Joint Commission simplified its ORYX requirements for healthcare organizations and eliminated previous requirements for specific percentages. Time frames for collecting and submitting data were not changed.[25]

The year 2000 will bring further development and refinement. As hospitals have worked to resolve early issues related to vendor selection and data submission, they will see the next wave of ORYX involving the adoption of a set of hospital core measures that will be used to evaluate hospital care and benchmark performance.

The core measures first surfaced in 1998 when the Joint Commission announced that it had developed initial core performance measures ("a standardized quantitative measurement tool that has precisely defined specifications, including risk-adjustment methods as appropriate, and standardized data collection protocols") as the first step toward evaluating clinical care and patient outcomes.[26] Plans were made to solicit feedback from healthcare organizations and others to further identification and development of this set of measures.

In May 1999, after consideration of comments and feedback, the Joint Commission's Executive Committee approved five initial priority areas as a starting point for core measures:

- acute myocardial infarction (including coronary artery disease)
- congestive heart failure
- pregnancy and related conditions (maternal and newborn care)
- pneumonia
- surgical procedures and complications

The Joint Commission has since received public comments on these initial core measures, and it is set to review them early this year. If approved, this set of initial core measures will serve as the foundation for an accreditation process that evaluates outcomes as well as hospital performance based on a quantitative review of data.

"Be Prepared" and Other Lessons Learned

Healthcare professionals throughout the country who have had significant involvement in preparing or facilitating a Joint Commission survey generally hold similar beliefs. Here's a synopsis of some of the lessons they have learned and thoughts about the accreditation process today:

- *Lesson 1: Even though Joint Commission accreditation is awarded for three years, never wait until the night before, days, weeks, or anything less than 12 months before to begin planning and preparing for your survey.*

"Constant preparation and planning and having the support of a dedicated team," help to ensure a successful survey, according to Tim Selz, president and CEO of Provena Saint Therese Medical Center, a 350-bed acute care facility in Waukegan, IL, that received accreditation with commendation last fall.

Hargreaves agrees. "An organization should strive to maintain a state of readiness and not have to plan or prepare right before a scheduled survey," she says. "Compliance should be continuous and ongoing."

- *Lesson 2: Establish a consistent means to review your organization's level of compliance with the standards. Apprise executive management of organizational compliance with regulatory standards on an ongoing basis.*

At Rush-Presbyterian, multidisciplinary chapter teams of healthcare professionals continually assess Joint Commission organizational compliance though reviews and discussion of the Accreditation Manual standards. Each chapter of the manual is assigned to an integrated team of professionals who are knowledgeable about the systems and processes in place at the facility, Hargreaves says.

The chapter team makes "assessment of compliance" for each standard. When issues of noncompliance are identified, the team puts together a plan for corrective action with a target date for follow-up. When its work is done, each team submits a final report to the quality management department and outlines its findings, actions taken, and responsible parties. The quality management department then reviews each report and aggregates the data from each report into a complete report.

- *Lesson 3: Be prepared for any surveyor, from any organization, to walk through the door at any time.*

"We had just finished celebrating our most successful Joint Commission survey ever, achieving a final grid score of 98.59 percent," remembers Tricia Truscott, RHIA, director of HIM at Carle Foundation Hospital in Champaign, IL. "Our hospital was awarded accreditation with commendation. Then, the very next day, the state suddenly showed up for a surprise review of our off-site ambulatory surgery facility."

Currently, there is little or no collaboration between the Joint Commission and other accrediting organizations (such as state agencies, ACS, or others) on findings and outcomes of reviews.

In this emerging era of healthcare accreditation, many hope to see a movement toward more collegial methods of oversight, including the sharing and exchange of information among accrediting bodies, such as the Joint Commission, state agencies, and others.

Time for Action

Will the accreditation process still exist on December 31, 2019? Most experts believe the answer is "yes." But opinions vary widely on what it will look like.

Some believe that the system will be comprised of greater numbers of accrediting organizations with varied emphases and responsibilities. Others believe that a single entity such as the Joint Commission, NCQA, HCFA, or some other organization will emerge as the single authoritative source in healthcare accreditation.

Whichever scenario may prevail, there is almost unanimous agreement that the main emphasis of healthcare accreditation in the next few decades will focus on improving the quality and safety of healthcare. Many also believe that a data-driven performance measurement system will be established to evaluate organizational performance and outcomes.

At this point, the 1999 OIG report appears to be emerging as the foundation for further changes in healthcare accreditation. Based on the findings and recommendations in this report, we can expect HCFA to take on an expanded role in the oversight of the accreditation process. Much as hospitals and other healthcare organizations are reviewed by their state and by private accrediting agencies, so too will the accrediting agency be reviewed and held accountable for its performance.

And what about healthcare organizations that choose to be nonaccredited or relinquish their voluntary accreditation status? Unless a complaint or adverse event triggers an investigation, nonaccredited hospitals currently undergo limited external reviews by accrediting agencies. The OIG recommends that HCFA play a role in determining an appropriate minimum cycle for certification surveys of nonaccredited hospitals while continuing to support inspections in response to complaints or adverse events.

And where does this leave HIM professionals? One of our most important responsibilities is to facilitate and lead change within our organizations. As changes in accreditation present us with a set of new and exciting challenges and opportunities, we must be prepared for them. Rather than waiting to be affected by these changes, we must embrace them and pursue these opportunities to effect change in our organizations. As HIM professionals, we must redesign systems and processes to

facilitate improvements in the collection, storage, reporting, submission, and validation of information used to measure and accredit organizational performance.

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