

The Role of Accreditation in an Era of Market-driven Accountability

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Accreditation has been widely used to promote accountability in healthcare. However, with the rise of both purchaser and consumer demand for broader and more detailed information on performance beyond licensure and professional self-regulation, especially at the provider level, the role of accreditation is less clear. We hypothesize that for accreditation to be a critical part of a market-driven, consumer-focused healthcare system, accrediting bodies must enlarge their scope of assessment with an emphasis on clinical performance of providers, revise and expand their level of reporting and transparency of assessment, and broaden the base of their governance. A new approach to accreditation could enhance accountability by (1) building on an existing framework and data-collection structure that are proven elements of quality assurance in multiple healthcare sectors; (2) expanding existing involvement of both public and private entities in the process; (3) building on existing linkages to professional and regulatory bodies; (4) providing greater flexibility, compared with regulation, in responding to change; and (5) having a defined source of funding. By these means, accrediting bodies will both improve accountability and successfully drive quality improvement.

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Accountability has been defined as “the procedure and process by which one party provides a justification and is held responsible for its actions by another party who has an interest in the action.”¹ Accountability in healthcare has been characterized as being driven by 3 major forces: regulation, professionalism, and the market.² Parties that may seek accountability include those directly affected by healthcare services (patients, family) or those that directly or indirectly pay for the services (insurers, employers, employees, and taxpayers). We will refer collectively to this group of interested parties as “the public.”

Accountability can be achieved by informal, subjective means or through the exchange of information using some formal set of metrics. One mechanism used to foster accountability in healthcare is accreditation and/or certification. The accreditation process involves an external entity evaluating a given organization against a set of predetermined requirements, critical attributes, or performance benchmarks.³ Certification

denotes a similar process, but usually refers either to determination of individual competency or to evaluation of a single program or set of activities.

The related, but separate, process of licensure derives from legal and regulatory processes and involves the determination by a public agency of whether a given entity or person meets basic qualifications or competencies seen as necessary for providing services to the public.⁴ The processes of accreditation (or certification) and licensure, and the concept of professionalism (specifically, professional self-regulation), have been closely linked in the past. Indeed, accreditation most often is developed by a professional group or industry as a self-regulatory alternative to more restrictive and extensive public regulatory or licensure requirements.⁵⁻⁸ However in the recent past, consumerism and the market have begun to play more prominent roles in driving accountability.⁹

Our major premise is that the process and content of accreditation can, and should, be expanded to meet the growing demand by the public (consumers, insurers and purchasers) for accountability beyond licensure and professional self-regulation. To this end, accrediting bodies must be willing to (1) broaden their focus of assessment to include an emphasis on evidence-based performance, including clinical functions; (2) revise and expand their level of reporting and transparency of assessment; and (3) open and enlarge the base of their governance. Although similar changes are needed (and are beginning to take place) in public-sector programs and within the areas of professional certification, this paper will focus on private-sector accreditation.

THE IMPETUS FOR CHANGE

Although accreditation has played a substantial role in ensuring accountability, its roots in professionalism and regulation, its traditional reliance on structural

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assessment, and its use of “pass-fail” public reporting raise major concerns about its usefulness beyond providing a “floor” of accountability related to regulatory or professional issues. There are increasing concerns about the effectiveness of professionalism and regulation as the primary forces driving accountability. In addition, there is increased public understanding of quality and an enhanced ability to measure it.

Indeed, one of the hallmarks of an effective market is a high degree of symmetry of information between buyers and sellers, something that has clearly not been the case in healthcare in the past. If market forces are seen at least as balancing the forces of professionalism and regulation in driving and enhancing accountability in healthcare, there is a substantial need for more and more widely shared information on quality and cost in healthcare.

A substantial literature, including several reports from the Institute of Medicine (IOM), document marked variation both in the quantity and quality of care provided by hospitals, health plans, and other accredited entities.¹⁰⁻¹⁵ Because the public has become increasingly aware of this variation, demands for information on quality also have increased. These demands have come from public-sector and private-sector purchasers, consumers, and insurers.¹⁶⁻¹⁸ Although consumer use of performance information appears to be rather limited,¹⁹⁻²² both public and private purchasers and health plans are actively using performance data to inform consumer choice, develop network tiers, or provide financial and other rewards for performance.^{16,17} The IOM reports and the other studies cited also have cast doubt on our past and current reliance on professionalism and internal quality improvement mechanisms as the primary means of ensuring accountability. A full discussion of the benefits and limitations of professionalism are beyond the scope of this paper; however, there is a growing literature exploring this issue.^{23,24}

The IOM provides a useful list of desirable attributes for our healthcare system.¹⁰ Moreover, the creation of reliable, valid, and feasible measures of clinical performance, such as the Health Plan Employer Data and Information Set

(HEDIS[®]) developed by National Committee for Quality Assurance (NCQA) and the Oryx[®] set created by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), have greatly expanded the tools available for measurement.^{5,6,9} In addition, these organizations have taken steps to ensure that measures are timely and performance data are collected in a way that allows valid comparison between entities. These steps include development of detailed measure specifications, use of sampling frames, auditing of collection methods, and ongoing review and maintenance of the quality measures. Although the measures still are undergoing evolution, and there are technical and political issues related to extending measurement to the individual physician level, the use of clinical performance measurement is growing rapidly. Finally, the efforts of the National Quality Forum to create both standardization of metrics (voluntary consensus standards) and a framework for accountability in healthcare are accelerating progress in measurement and use of information on performance in healthcare.²⁵⁻²⁷

The emergence of a robust framework, an increased number and scope of valid measures, and greater market forces have heightened the call for more accountability in healthcare. However, there is no defined mechanism for gathering or reporting performance information for accountability purposes. Available options range from voluntary reporting by providers to creating regulatory or licensure-related requirements for reporting (Table 1). We propose, however, that a revised and expanded process of accreditation offers a number of important advantages, including:

- Building on an existing framework and data-collection structure that are proven elements of quality assurance in multiple healthcare sectors.

Table 1. Comparison of Approaches to Accountability

Characteristic	Voluntary Reporting	Accreditation	Regulation	Licensure
Existing framework of data collection and reporting	No	Yes	Yes	Yes
Public-private involvement	High	Moderate	Minimal	Minimal
Linkage to professional groups	High	High	Low	Low
Defined funding	No	Yes	Yes	Yes
Flexibility/responsiveness to change	High	Moderate	Low	Low
Extent of participation	Low	Moderate*	High	High

*High if combined with regulation and purchaser demand.

- Involvement of both public and private entities in the process.
- linkages to both professional groups and regulatory bodies.
- Greater flexibility, compared with regulation, in responding to change.
- A defined source of funding.

The most problematic disadvantage is the semi-voluntary nature of accreditation. However, strong pressure through contract requirements of private purchasers and health plans, or public purchasing and quasi-regulatory approaches that use “deemed status” for accredited entities (like the approach used by the Centers for Medicare & Medicaid Services [CMS] in the Medicare programs and by some states in regulation of hospitals and health plans) can go a long way to encouraging most, if not all, entities to undergo accreditation. For example, between state regulation and CMS requirements for participation in the Medicare program, nearly all hospitals undergo accreditation by a private entity through the regulatory doctrine of deemed status.

CHANGES NEEDED WITHIN THE ACCREDITATION PROCESS

Wider Involvement of Purchaser, Consumers, and Patients in Shaping Accreditation

To be responsive to public as well as professional needs, the input to and control of the accrediting process will need to be expanded to include more from consumers, purchasers (public and private), and payers. Although this does not lessen the role of professionals and those representing the entities that undergo accreditation in setting the standards and desirable levels of performance (especially for technical aspects of care), it does imply a higher degree of shared control. This shared governance will be increasingly important as the healthcare system struggles to deal with issues resulting from the public’s demand for increased accountability: for example, balancing the harm of misclassification of providers or plans (eg, ranking a person or entity low when they are actually performing well) against the public’s need for information, or deciding whether information about resource use and cost should be a part of evaluation and reporting. It is not clear whether shared governance can be accomplished simply by having advisory groups to accrediting bodies, or if fully shared control at board levels will be necessary. Some accrediting and certification entities have already created a broader role for public input. For example, public members now constitute about 25% of JCAHO’s 30-member board, and only 1 member

of NCQA’s 18-person board is from an entity accredited by NCQA.^{28,29}

Adopting a Broader Set of Evidence-based Performance Metrics and Data on Relative Performance

Most accreditation programs have relied primarily on documentation of structures and processes that demonstrate adherence to administrative standards. Although structural standards are very useful in some situations,³⁰ their exclusive use as a quality measurement tool depends on the largely unproven assumption that there is a strong and consistent linkage between the specified set of structures and performance in terms of clinical processes and outcomes.

The expansion of measurement beyond structure or administrative standards depends on the presence of evidenced-based clinical guidelines, as well as on the creation of reliable and valid measures of adherence to those guidelines. Both of these requirements have been met in a number of clinical areas,^{28,29} but substantial barriers remain to adapting guidelines for measurement at the physician-practice level.²¹ Along with the development of reliable and valid clinical performance measures, standardized and well-tested measures of patients’ experience of care have been created.³¹⁻³³ The addition of performance measures permits basing the accreditation decision on a set of evaluations that conform to the broad conception of quality articulated by both the IOM and the National Quality Forum.^{7,28} Performance measures also provide information that can be reported both to the provider for quality improvement and to the public for accountability.

Expanded Public Reporting of Evaluation

Accreditation decisions usually have been reported on a pass or fail basis, or even by just listing those accredited with no mention of those who attempted to achieve accreditation, but failed. However, where market forces demand information for choice, a pass/fail designation clearly is insufficient, especially in those situations where accreditation is essentially “required” for participation in an insurance program (eg, for hospitals in the Medicare program). With an expanded set of metrics, accreditation could provide a much richer set of information beyond pass or fail. For example, NCQA reports health plan accreditation status as commendable, accredited, or provisional, and ranks each plan (using 1 to 4 stars) on specific areas including access to service, credentials of providers, staying healthy, getting better, and living with chronic illness.²⁸ In addition, NCQA publicly reports in Quality Compass® the clinical performance of individual plans on a relatively broad set

of HEDIS® clinical performance measures.²⁸ JCAHO provides similar expanded information on both administrative and selected clinical performance measures reported by hospitals that it accredits.²⁹

SUMMARY

Accreditation has played an important historical role in demonstrating accountability within the healthcare system. As market demands for actionable information and accountability for costs and quality become more evident, accreditation could assume a pivotal role in ensuring that such data are provided. However, this will not come to pass without continued evolution of accrediting bodies to expand the scope of governance, measurement, and reporting.

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Correction Statement

Due to an editing error, the e-mail address for corresponding author Natan Kahan was listed incorrectly in the February issue (Kahan NR, Blackman S, Kutz C, Waitman D-A. A pharmacoepidemiological approach to investigating inappropriate prescribing in a managed care setting in Israel. *Am J Manag Care.* 2005;11(2):89-90.). The correct e-mail address is nkahan@leumit.co.il.