*International Journal for Quality in Health Care* 2000; **Volume 12, Number 3**: pp. 255–258

# The evolution of external quality evaluation: observations from the Joint Commission on Accreditation of Healthcare Organizations

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## Abstract

The Joint Commission on Accreditation of Healthcare Organizations, the oldest health care accrediting body in the world, currently accredits almost 20 000 organizations in the USA. Although continuing to be professionally-sponsored, accreditation's rapid growth in recent years has been driven by the external users of accreditation – government, purchasers, and public – rather than by the original users, the professionals themselves.

This experience in the USA suggests that over time successful external quality evaluation mechanisms throughout the world will involve representatives of the public, purchasers, and government in establishing standards and setting policies. Without this involvement, these stakeholders are unlikely to find the mechanisms credible in addressing their needs, and will seek alternatives – adding cost and duplication to the external quality evaluation system. Successful mechanisms are also likely to provide more detailed information about an organization's performance to the public, purchasers, and the government, while creating evaluation processes that provide for innovation and support improvement in efficiency, as well as quality, through incorporation of aspects of the Baldrige and European Foundation for Quality Management approaches to organizational excellence. Finally, successful evaluation mechanisms are likely to create a special focus on the safety of care, incorporating aspects of the International Organization for Standardization's ISO 9000 approach to quality management.

While the specific nature, priority, and timing of these changes will differ from country to country, they are likely to influence the evolution of external quality evaluation throughout the world. External evaluation of health care organizations' quality holds great promise, but its long-term success depends on responding to all those who will want to depend on it.

**Keywords:** accreditation, Baldrige, European Foundation for Quality Management, ISO 9000, quality evaluation.

In the USA, external mechanisms for quality evaluation of health care organizations began in the early years of the twentieth century, but their most rapid growth has occurred over the last two decades. The ExPeRT Project found that external quality evaluation mechanisms for health care have taken on four forms in the European Union: *visitatie*, accreditation, European Foundation for Quality Management (EFQM), and International Organization for Standardization (ISO 9000). There is a movement toward convergence among these forms, as political and commercial forces that favor standardization and comparability have joined with a realization among health care professionals that these models are complementary. Because the USA has had the longest experience with external evaluation using the accreditation model, the evolution of accreditation within the USA may provide helpful insights into the potential challenges for external quality evaluation mechanisms in other countries.

## The Joint Commission on Accreditation of Healthcare Organizations

The Joint Commission currently accredits almost 20 000 ambulatory care, behavioral health care, home care, and long-term care organizations, hospitals, laboratories, and health care networks. Although accounting for less than one-third of Joint Commission accredited organizations, over 96% of hospital beds in the USA are in accredited hospitals. While the Joint Commission is the largest US accreditor, the other accrediting bodies generally reflect a similar model.

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The accreditation model for external evaluation of health care organization quality was initiated by the American College of Surgeons (ACS) in 1917, and evolved into the Joint Commission in 1951. Until 1964 this evaluation mechanism was driven, the standards set, and the results used entirely by health care professionals – by hospitals to improve the quality of care, to recruit staff, and to qualify for accreditation of their graduate education programs. And, until 1964 there was no charge for the survey – the costs were paid by the ACS, and, after 1951, by the founding organizations of the Joint Commission. Nevertheless, by 1950 only about 3000 (50%) of US hospitals were accredited, and no other types of health care organizations expressed interest in accreditation [1].

Although the initiation of accreditation in the USA was independent of any government, the Joint Commission's current pervasive influence on US health care is the result of governments', and, subsequently, purchasers' and the public's use of accreditation. In 1965 the US government established the federally-funded Medicare program for older Americans. The enacting legislation created 'deemed status', by which any hospital accredited by the Joint Commission would be 'deemed' to be eligible for the program. While still fully controlled by health care professionals, accreditation now had a new user: the government. This was the first step toward both substantial growth in accreditation and significant changes in the accreditation process.

## Users of accreditation

From its inception within the ACS program, accreditation focused on helping health care organizations to improve the quality of care. With deemed status, health care organizations were joined by new users of accreditation: the federal government and, later state governments, 45 of which now use accreditation in licensing hospitals. As the federal government began to fund other care settings, it established standards for home care, laboratories, ambulatory surgery centers, and hospices, for which the Joint Commission and other accreditors then received deemed status. Thus, government became a prime user of accreditation.

By purchasing health insurance for their employees, employers are the principal non-government funders of health care in the USA. In the 1980s, as the rising costs of this insurance became a threat to global competitiveness for US businesses, some employers and many insurance companies began making these purchases based on value, i.e., cost and quality (reflected in accreditation). Their demand for cost control also led to new payment mechanisms that capped the amount paid per patient or condition, forcing health care organizations to seek efficiencies in care delivery.

Further, employees began contributing to their employer-funded insurance premiums and paying copayments when receiving care. Becoming price conscious, but also worrying about the effects of cost cutting on the quality of care, they too became 'users' of accreditation to help choose among health plans and provider organizations based on value. In addition, with the growth of consumerism in health care, patients and their families began to demand more involvement in decision-making about their care, including where to get care. Accreditation became a source of information that consumers could use in this decision making.

Finally, over the past 5 years purchasers, consumers, and government have become increasingly concerned about the safety of care, and expect accreditation to address this concern [2].

## User impact on accreditation

This expansion in the users of accreditation has had significant effects on the evolution of accreditation in the USA. First, if the public and its government are to rely on accreditation, it wants to have its perspective heard in setting policy and standards for accreditation. The Joint Commission responded in 1982 by adding public members to its governing board; there are now six public members on the board and three on every professional and technical advisory committee. In 1999, a Public Advisory Group on Healthcare Quality was formed to advise the board on policy issues. Members of the public also expect the Joint Commission to respond to their quality-related concerns about accredited organizations. Therefore, the Joint Commission created an Office of Quality Monitoring with a toll-free number that the public can call with their complaints; if the complaint is standards-related, the Joint Commission will look into it through correspondence or visit with the organization. Unless the Joint Commission was willing to be responsive, the public would not view the accreditation process as being a credible source of information about health care organizations' quality.

The second effect of the expanded use of accreditation has been its role in meeting the increasing demand for public accountability of health care providers. This demand stems from concerns about both the cost and quality of care. The latter concern became a public issue following studies by Wennberg [2] that demonstrated significant geographical differences in the rate with which certain procedures are performed – apparently unrelated to differences in patient populations or health outcomes – which raised public consciousness about the lack of scientific data to support important health care decisions. The Joint Commission responded to this demand by publicly disclosing more than only an accredited organization's accreditation status: in 1994 the Joint Commission began issuing a Performance Report on each organization. This Report includes the organization's accreditation status and its performance in each of the major foci of the standards (e.g. respect for patient rights, medication use, infection control, credentialling of physicians), the area(s) in which it received recommendations for improvement, and national comparisons to similar organizations. To make these Reports accessible at no charge, in 1997 they were placed on the Joint Commission web site.

The third effect of the expanded use of accreditation derives from increased concerns about the safety of care, driven both by media coverage of adverse events and by the growing professional recognition of the frequency of their occurrence [2]. There is a high risk for serious adverse events in health care because of its complexity, its dependence on human knowledge, skills, and judgment, and the potential consequences of errors. In order to learn how to prevent their recurrence, these events must be recognized and analyses of their underlying (i.e. 'root') causes conducted. Concern about the frequency of serious adverse events ('sentinel events') led the Joint Commission to:

- Develop a policy on sentinel events and accreditation standards for how the health care organization and the Joint Commission should respond when a sentinel event occurs. The policy is designed to set expectations for root cause analyses and to build a national database of sentinel events, including the results of associated analyses, as an educational resource.
- Work with the government to maintain legal protections against plaintiffs' discovery of root cause analyses that are reported to the Joint Commission. This protection is prerequisite to building a comprehensive sentinel event database.
- Collaborate with an ISO 9000 registrar to explore the potential for ISO 9000 quality management approaches to reduce errors in health care organizations. The process control and self-audit required by ISO9000 provide tools for standardization of key processes that might contribute to reducing errors and adverse events.

The fourth effect of the expanded use of accreditation stems from the desire to decrease health care costs. In 1994–1995 all the standards manuals were revised to focus on those activities that are believed to be most associated with the safety and quality of care; to introduce the principles of continuous quality improvement, as reflected in the US Malcolm Baldrige Quality Award and its EFQM counterpart; to be patient-centered (i.e. focused on those activities that are important for the patient and the patient's experience); and performance-based (i.e. focused on the goals of key processes, rather than specifying how the goals are to be achieved). These revisions give health care organizations the freedom to be innovative in improving efficiency while improving the quality of care [4]. In addition, in 1997 the Joint Commission began developing cooperative agreements with other US accrediting bodies. Under this program, an organization that has a care delivery component accredited by another accreditor, need not have the component reevaluated when the Joint Commission accredits the parent organization. This policy reduces both cost and duplication of effort for the health care organization. Finally, in the same year, the Joint Commission created an advisory group composed of representatives from major US employers to learn about the information needs of those who pay for health care.

## Lessons for the future

The evolution of US accreditation provides potential lessons relevant to any mechanism for the external evaluation of quality. While US accreditation continues to be professionally-sponsored, with the ultimate goal of improving the safety and quality of care provided to the public, its characteristics changed significantly over time. Some of these changes (e.g. the introduction of performance measurement into the accreditation process) were based on scientific advances. This paper focuses on those changes that were driven by new users of accreditation: the government, purchasers, and the public. When professionally-controlled external evaluation was initiated in 1917, it was not contemplated that it would directly serve the needs of government, other purchasers, and the public. But in the USA, the driving force behind the growth of accreditation were the needs of these new users, which made it a reasonable investment for health care organizations and the health care system. The degree to which accreditation helps organizations improve increases its value, but is not the primary reason most US organizations seek accreditation today.

What might this US experience mean about the future of mechanisms for external quality evaluation in other countries? First, while professionally-sponsored, the mechanisms are likely to begin to involve representatives of the public, purchasers, and the government in establishing standards and setting policies. Without this involvement, these stakeholders are unlikely to find the mechanisms credible in addressing their needs, and will seek alternatives – adding cost and duplication to the external quality evaluation system.

Second, while a degree of confidentiality is necessary in order for a health care organization to share freely its inner workings with reviewers, that confidentiality is likely to be tempered over time by the government's, purchasers', and public's desire to have more detailed information about an organization's performance. Again, refusal to respond to this desire is likely to result in a search for an alternative.

Third, the mechanism will need to recognize the pressures upon health care organizations to be efficient. This requires creation of an evaluation process that provides room for innovation and encourages the continuous improvement in quality and efficiency which is embedded in the Baldrige and EFQM approaches to organizational excellence.

Fourth, the mechanism is likely to need to create a special focus on the safety of care, perhaps incorporating relevant aspects of the ISO 9000 approach to quality management. All the best intentions and improvements will lose credibility in the eyes of the public if they do not believe that their safety is a priority.

While the specific nature, priority, and timing of these factors will differ from country to country, they are likely to influence the evolution of external quality evaluation throughout the world. External evaluation of health care organizations' quality holds great promise, but its long-term success depends on responding to all those who will want to depend on it.

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**Accepted for publication 28 January 2000**