Widening the scope of accreditation – issues and challenges in community and primary care

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Abstract

Accreditation systems first developed to improve the quality of hospital care. As health care systems move towards a greater emphasis on primary and home care, accreditation systems are developing to address quality in this more diverse sector. This is more problematic, since there is little agreement about the precise functions to be undertaken in non-hospital care and there is no uniform organizational structure. This paper addresses the issues raised in developing quality in these very different organizations and examines the progress being made.

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provided outside hospitals, is a case study in the difficulties encountered in defining the parameters of primary care accreditation. Not only is non-hospital care made up of many different services, but also, in response to the pressures on modern health care systems, the traditional boundaries are themselves moving. Secondary care providers are moving into what has traditionally been the province of community health services and primary and community health care workers can work both in and with hospital services [3]. Consequently there is widespread debate as to the skills required of practitioners who work across organizational boundaries. What constitutes good quality, professional, community-based care is potentially more difficult to define than what constitutes good quality, hospital-based clinical care.

Three modes of expanding the applications of accreditation

A crude distinction can be drawn between three different types of accreditation which have appeared to address community and primary care services. First, there are those systems of accreditation which have developed as an extension of the approach used by hospital accreditation systems. Second, are those which have developed specifically to address particular services. Third, are the systems which have developed as an extension of the monitoring of the work of primary care practitioners.

The development of hospital accreditation systems

Successful hospital accreditation bodies have sought to expand their activities. During the 1980s the growing concern about quality of service provision generated a demand for standards and accreditation which was identified by the large accreditation systems as an opportunity to expand the markets in which they operate by adapting hospital accreditation to other organizations [7]. In the USA and Canada, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Canadian Council on Health Services Accreditation (CCHSA) have both developed standards and assessment processes for a wide range of services outside hospitals. The Australian Council on Healthcare Standards (ACHS) has a survey process for nursing homes, community centres and day procedure centres in addition to acute hospitals [8].

Accreditation systems developed for hospitals have moved from describing organizational processes in hospital departments, to examining the processes of care experienced by patients [9]. This involves describing the complex health care system through which a patient travels in the pursuit of treatment. Even so, the health care system is confined to a single organization. The patient experience approach, although intuitively relevant for describing primary care, is difficult to standardize outside hospital for a number of reasons. The primary care system has no identifiable boundaries and many different professionals in a variety of locations working for a range of employers can contribute to the care of patients. Patient care does not follow a pattern which can be described in a relatively simple organizational system [3]. Furthermore, the emphasis on organizational systems is less easy to justify. Whereas in a hospital, policies and procedures can create an environment which aids clinical practice, the primary care environment is less controlled and less open to standardization. The objective of home care is more likely to be the provision of individualized care. There is therefore perhaps greater pressure to establish that professionals are individually competent and that outcomes can be assessed.

As services outside hospital tend to be provided by a range of different organizations, a single patient is often the client or patient of a number of different providers. An elderly person recovering at home after surgery may require nursing, general medical care, physiotherapy, dietetic and pharmacy advice as well as social care. Some of the specialists providing this input may be employed by hospitals, community services, medical practices, or specialist organizations. This suggests that an accreditation approach which is focused on care for this type of patient would have to find ways of combining all the organizations contributing to the care package.

The JCAHO, for example, developed an approach for accrediting ‘networks’ of provider organizations [10]. This came about because health care funding bodies moved towards buying ‘care plans’ or packages of care on behalf of groups of their clients. Aspects of services of individual organizations are sewn together within a health plan. To accredit the plan as a whole, each contributing organization would be accredited and these accreditation scores combined. This would produce an overall accreditation score or outcome for the whole network.

However, accrediting the organizations employing the staff who have contact with a patient does not reflect the experience of the patient as he or she passes between the organizations or between the staff from the different organizations who together deliver the services. A significant factor in determining the quality of care received by the patient is the relationships between the staff in the different organizations. Within the new philosophies of accreditation there is a need to focus on the patient. In the multi-organizational world of non-hospital services, this has proved problematic.

The JCAHO, having identified networks, is moving towards a system where standards can be developed for a whole health plan or network, rather than for its constituent parts – which can perhaps be described as a shift from methodological individualism to methodological holism in the assessment processes. Effectively, the network is becoming the unit of organization. The CCHSA has been moving in a similar direction, accrediting the services of a whole region.

Identification of the role of the individual parts of a service and their impact upon the patient has been made more difficult as health services have moved away from a model in which patient care corresponds to organizational structures. Patient care is better provided by multi-disciplinary teams, the members of which may be employed by different departments.
within an organization, or indeed by different organizations. The CCHSA, the JCAHO and the ACHS have committed themselves to what is currently termed 'a patient-care focus' or 'client-centred care' [9]. In so doing they have found that it is no longer possible to describe standards in departmental terms. Instead the standards have had to be rewritten to reflect the passage of the patient through a variety of different hospital departments. The CCHSA and the JCAHO have both attempted to extend the concept of service outside the hospital boundaries, using the patient experience before admission and on discharge. This has required standards to incorporate the workings of a variety of different providing organizations.

This change in emphasis has been accompanied by an additional, far-reaching question. Is the purpose of accreditation to assess how well the organization conforms with process standards which suggest how well it could perform? Or should accreditation systems aim to identify how well the organization has performed? In the case of networked services, should the accreditation system demonstrate how well the range of services that make up the individual patient's experience of health care is performing? That is, using an analogy with a runner in a race, the purpose of the accreditation approach is not to see how well the individual limbs are performing, and therefore deduce the ability to run; instead it is to assess how well the athlete is running. This requires an understanding of how the various parts work together to produce overall performance. The greater the number of constituent parts, each operating independently, the greater the difficulty in assessing precisely where the system is failing.

**Community services accreditation**

In the USA and Australia, there are examples of accreditation systems which have been designed specifically to address the quality of what are termed community services. In the USA, the federal government enacted minimum safety standards for home care providers. The creation of standards opened the door, in a country already used to quasi-official peer review systems, for an accreditation system (the Community Health Accreditation Program) to monitor compliance with them [11]. In Australia, where a number of state governments had already accepted accreditation as a useful monitoring tool, community services accreditation was actively encouraged by government agencies. The national Community Health Accreditation and Standards Program (CHASP) is run by the Australian Community Health Association created to implement CHASP across Australia [12].

The development of these accreditation systems reflected government rather than professional concerns about quality. In the USA the main pressure was government concern about the lack of quality controls in this sector which were reflected in the lack of professional bodies to regulate training and activity. In Australia, the concern was to standardize the provision of services which had evolved in different ways across the country [13].

Another focus for networks of services has been the development of accreditation standards particularly for services which cut across organizational boundaries such as the range of services provided for cancer patients. In the UK, one regional office of the National Health Service has developed an accreditation system based on standards describing cancer services. Similar accreditation systems exist in France and in The Netherlands.

In the USA and Australia, accreditation systems have evolved specifically to examine services provided for the care and rehabilitation of those with brain injuries. In the USA the Rehabilitation Accreditation Commission (RAC) evolved to accredit services which span organizational boundaries [14]. In Australia, the Brain Injuries Rehabilitation Program developed standards and a review process to evaluate the quality of care provided [15].

These two accreditation programmes have developed some slightly different characteristics from their hospital siblings. It seems that there is a greater recognition of the activities of professionals in this area for multi-disciplinary cooperation. In addition, the rehabilitation services appear to recognize the importance of clinical management upon the resulting health status of each individual patient. There is therefore an emphasis, in this form of accreditation, on the use of outcome measures which must reflect the way in which rehabilitation services have developed their own internal management processes.

Traditionally, accreditation systems have refused to prescribe norms for activities. This may have resource implications for organizations or may indeed put them out of business if accreditation is denied. However, the new networked accreditation systems for specific conditions, such as cancer and brain injuries are more likely to include norm-based standards. For example, the RAC demands the achievement of minimum rates for patient admissions. If these are not achieved, the organization is considered to be too inexperienced to provide adequate care and also to not generate enough income to provide adequate facilities [14].

The use of norms based on work experience to determine the competence of both practitioners and of organizations to cope with particular conditions is emerging as a preferred option when dealing with the accreditation of specified services such as maternity, cancer and brain injuries. It appears that when accreditation changes its focus from organizations to services, the orientation of the standards moves away from organizational practices towards what may be termed organizational credentialing. Service definitions, therefore, appear to reflect concerns about experience levels rather than the readiness of the organization to operate according to predefined criteria of a 'good organization'.

**General medical practice accreditation**

The third application for accreditation outside of hospitals has been for organizations providing personal medical and clinical care. This application has developed from a concern about improving and maintaining the quality of care provided by independent medical practitioners. Following a trend, in a number of countries, to monitor the quality of the
environment, the systems used to support independent medical professionals frequently also include monitoring the clinical performance of individual practitioners. In most cases this form of accreditation has been developed by national professional bodies representing primary medical care practitioners. It is different from accreditation of organizations for training purposes, and has much more in common with the organizational accreditation systems described above. For example, the Netherlands College of General Practitioners has developed an accreditation programme for general practice which is now under discussion by other bodies representing the professional interests of general practitioners. In Australia, in 1992, the Royal Australian College of General Practitioners (RACGP), the Australian Medical Association and the government jointly published a document entitled 'The future of general practice: a strategy for the nineties and beyond'. This included an outline of the principles upon which an accreditation system for general practice could be based. The document stated that the RACGP was the arbiter for standards in general practice. This paper proposed that an independent and voluntary system of general practice accreditation be developed to enhance the delivery of services and facilities by general practitioners [16]. The UK Royal College of General Practitioners has developed a variety of approaches to examining the quality of general practice and in 1995 proposed primary care-based team accreditation to assess the organizational aspects of general practice. In the USA, the American Medical Association also has developed an accreditation system for physicians in practice in primary care settings [17]. Potentially one of the most comprehensive accreditation systems of its type, it covers the environment in which the physician practices, but also includes an assessment of the competence of the physician.

The genesis of these developments, as for hospital accreditation systems, resulted from pressures specific to each country. The Australian and UK systems have developed as a result of increasing pressure from governments and local health authorities to improve regulation of the quality of primary medical care. Whereas in Australia the Royal College dominated developments in this area, the UK has seen a wide variety of approaches. Each local health authority is required to promote the quality of general practice and a number have developed accreditation systems. The King's Fund adopted an accreditation system for primary care teams which has been developed by a number of health authorities for local use. The UK Royal College of General Practitioners is having to compete with these other initiatives and it is not clear which will succeed [18,19]. In the USA, the regulation of medical practitioners was felt to be in the hands of private insurance companies, each of which had developed its own standards and assessment processes. The American Medical Association effectively offered a means by which to standardize approaches to the assessment of quality in the personal medical care sector and to relieve practitioners of the burden of numerous repeated assessments (Table 1) [17].

**Organizational versus professional assessment – the appropriate basis for accreditation?**

Accreditation systems began with concerns about the organization of hospitals describing the structures and processes necessary for ‘good organizations’. When moving into the health care services provided outside of hospital walls, there has been a tendency to follow the traditional approach with the emphasis still placed on organizational structure. This has resulted in a search for organizational structures which can form the basis for accreditation. As explained above, the difficulty frequently encountered in community and primary care services is the lack of consensus upon a single appropriate organizational form, and in some cases, what might be described as the total lack of any identifiable organization [20].

In contrast, community services are a collection of different services brought together under an administrative umbrella. In most of the health care systems studied and certainly in the UK there is no operational reason underpinning the current organizational structure. Although there are defined management units, known as Trusts, which provide community services, there is no recognized form of organization, as each Trust can provide a range of services.

The medically-based personal services (referred to in the

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**Table 1 The five components of the American Medical Association’s accreditation system**

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
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<tbody>
<tr>
<td>1. Physician credentials</td>
<td>Including the academic, training and work histories of physicians. The physician credentials cover a wide range of experience and knowledge including education and training, license and registration, work experience, personal qualifications, ethical behaviour, participation in continuing medical education programmes and involvement in peer review</td>
</tr>
<tr>
<td>2. Personal qualifications</td>
<td>Such as an agreement to abide by the AMAs principles of medical ethics</td>
</tr>
<tr>
<td>3. Environment of care</td>
<td>Which reviews the clinical, operational and management systems in a physician’s office such as office procedures and policies, staffing levels and staff performance and an assessment of the completeness, accuracy and legibility of medical records</td>
</tr>
<tr>
<td>4. Clinical performance</td>
<td>As measured against national benchmarks including an examination of processes of care and compliance with guidelines on activities such as preventive care, early detection of disease and an assessment of the appropriateness of services provided</td>
</tr>
<tr>
<td>5. Patient care results</td>
<td>Including patient satisfaction surveys, to provide physicians with feedback on their patients’ assessment of the care they receive and also assessments of effectiveness based on clinical outcomes, cost effectiveness and health status of patients</td>
</tr>
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UK as primary care) are no easier to describe. There is a wide variety of organizational structures in different countries and frequently considerable variation within a country. Analysis of the structures is further complicated by the fact that, unlike a hospital structure which organizes the work of clinicians, primary care services tend to be dictated by the work practices of individual clinicians. As a consequence, there is little universally recognized pattern or structure to the services that are provided. The success of hospital accreditation systems lies in the consensus achieved across the many professions which contribute to the working of a hospital, about the standards to define its work. There is no such consensus in primary and community care services which means that any search for consensus has to recognize the variation in the organization of services.

The complexity, diversity and multi-disciplinary nature of community health services in Australia means that developing standards is a challenging task; such standards must be specific enough to be useable, and capable of being evaluated once they are applied, but broad enough to cover diverse local circumstances. [20]

Primary care presents a very particular problem for accreditation systems. As mentioned earlier, hospital accreditation systems have been wary of defining norms for practice. Equally, they have avoided the vexed issue of assessing the practice of individual clinicians. They have attempted to follow the recommendation of Donabedian that:

‘...managerial control of doctors by managers is as illogical as medical control of managers. What is needed is a partnership of skills and it is likely that the separation of contractual audit from educational audit will give both managers and the professions their own territory and responsibility’. [21]

In hospitals, accreditation has been directed at the organization and processes of hospitals which in general can be considered to be under the control of managers. Clinical audit, clinical guidelines and other related activities which examine the clinical competence of doctors have fallen outside the standards of accreditation. However, the boundaries are becoming blurred as clinical competence is felt to be related to hospital systems. Equally there is a growing desire on the part of accreditation systems to define performance in terms of clinical outcomes.

In primary care the ability to distinguish between the work of the individual practitioner and the system is less clear. The discussions of quality assessment in primary care have demonstrated the difficulty in separating the GP from his or her organization. It is not clear ‘whether the individual doctor or the practice should be the focus’ [22]. One solution has been to bifurcate the activities, calling methods to assess the individual doctor ‘certification’ and those to assess the practice ‘accreditation’. However, this distinction is only workable if the original model of accreditation is used – that is the standards reflect the organization’s ability to provide an environment in which to optimize clinical practice. If the emphasis changes to performance, then accreditation must reflect how well the organization delivers care to patients.

In addition, the values of community and primary care are somewhat different from those found in hospital services. The tradition of personal care has resulted in an emphasis on the individual patient. Standards are therefore required to reflect the participation of patients in decision making and respect for the individual is a common feature of the newly emerging accreditation standards. The standards developed by RAC in the USA show how the standards for what they term integrated care have developed. Not only do the standards examine the work of the members of the rehabilitation team, but they also focus on the extent of coordination of the services to promote the re-integration of the individual patient into the local community. Again the emphasis is on the service delivery process and experience of providing care rather than the structure and the processes of the organization.

Peer review of general medical practice, certainly in the UK, may present difficulties in terms of finding qualified surveyors who will be willing and able to participate. The usual model for accreditation surveys requires three surveyors from different backgrounds [23]. For general practice accreditation a general practitioner, a practice manager and a nurse or other primary care team-worker usually make up the team. The main problem facing national accreditation schemes is the scale of the primary care organization. Relative to hospitals, primary care organizations are small, but still require 2 or 3 days of surveyors’ time. This means that a proportionately high cost falls on a relatively small-income organization. In addition, their small size means that there are large numbers of practices to be surveyed which in turn places great demands upon the accreditation organization, to find the required number of surveyors and to administer large numbers of surveys.

Incentives to participate

The outcomes of hospital accreditation surveys are frequently expressed in numbers of years: that is time between surveys. High levels of compliance with standards provide greater time between surveys. In the non-hospital systems examined similar approaches were found. The time between surveys is a complicated issue for accreditation systems. Too long between surveys and the standards will have changed and the organization may have changed its practices and therefore no longer complies with the standards. Too short a time and the organization suffers stress at too many reviews. The difficulty in setting the appropriate time limit is often due to the rate of change in the definition of good practice which determines the content of the standards. In community services and in general practice there are certain areas where some activities should be monitored annually (for example the conduct of clinical audit activity) and yet for others the monitoring could occur only once every 5 years. If the latter are to be included in standards it would be necessary to find a suitable time horizon for assessment. Furthermore, if
incentive payments are to be attached to the outcome of accreditation then there is a need to determine the appropriate time period between surveys to ensure fair and equal treatment of practices. This is further complicated by the issue of who should pay for the survey. If the participating organization has to pay, the accreditation body may be open to criticisms if the time between surveys is felt to be too short. Equally those organizations which are found to have poor compliance and are given, say, 1 year's accreditation will have to pay another survey fee if they wish to repeat the process and gain a better accreditation score. Organizations providing community and primary care services are often small organizations with limited resources, so fees are an important consideration. If accreditation is voluntary, the organizations may feel they are unable to afford to participate. Indeed, the examples of general practice accreditation shown above suggest that the motivation to participate in accreditation frequently has to be driven by purchasing agents such as insurance companies, who not only have to bear the cost of the accreditation process but also have to offer financial incentives to persuade the organizations to participate at all.

In a number of the community- and general practice-based accreditation systems the incentives to take part in accreditation have not come from the participating organizations. They have been developed, in the case of the home care services in the USA or in Australia, as a response to federal concerns about the quality of service. The home care services in the USA achieve deemed status for the receipt of Medicare and Medicaid monies. The rehabilitation scheme in Australia has been devised by the Motor Accidents Authority acting for employers' insurance companies. The general practice-based accreditation scheme in Australia was designed to be tied to incentive payments to general practitioners. These accreditation systems are driven by external concerns to promote quality and have a regulatory aspect to them. The accreditation schemes which examine individual professional performance and knowledge are of a different nature but they too are regulatory. They are intended to control the standards of the professional practice of individuals and to weed out incompetent professionals.

Clinical performance measures and accreditation

Many of the accreditation systems reviewed above have accepted the need for outcome measures as an integral part of the assessment of primary care. But, as yet, outcome measures are poorly developed and there is little consensus on the appropriate methodology for approaching them. Indicators assessing structure and process suggest where there are problems in the functioning of the organization or services. But development of such indicators for non-hospital services would require greater uniformity of approach in the structure and organization of these services. The traditional approach of accreditation systems focuses upon the errors in the systems of care delivery. However, in the primary care sector it is yet to be decided whether the focus of concern should be the organization which provides the environment in which the practitioner works, the ability of the team of professionals to work together, or the work of the individual practitioner.

It is possible to speculate that primary health care will be more concerned with the interaction of individual patients and individual practitioners. Much of this will depend upon whether primary care services move from loose associations of practitioners working together, or whether they can form organizational structures which are capable of systems design. It is equally possible that primary care will demand a new approach to thinking about the health care organization in which quality is determined by the working processes of team members in hierarchical organizations rather than the hierarchical organizational structures associated with hospital management.

In discussions of the applicability of the theory and process of accreditation to primary care, what must be remembered is the sheer scale of the exercise. In comparison with the number of hospitals, the number of general practices is vast. There are complex issues about the time and resources which would need to be devoted to the accreditation of all general practices in the UK. And although this is a vitally important part of the health service, there are many other services and health care professionals who are also interested in and, it could be argued, in need of similar quality improvement programmes.

Whether accreditation is achievable for the new agenda for health services is yet to be determined. Whether it can be afforded is another question. As health services become more complex, so do the definitions of public accountability and the systems needed to regulate and monitor the provision of health care. Accreditation systems are beginning to provide solutions to the problems, but these solutions are many and varied. They differ in emphasis and approach. Whether universal agreement on what form accreditation should take in the future is possible or not remains to be seen.

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