All Theses and Dissertations (ETDs)

January 2010

The Pursuit of Accreditation in Children's Mental Health Care: Motivations, Experiences, and Perceptions

Madeline Lee
Washington University in St. Louis

Follow this and additional works at: https://openscholarship.wustl.edu/etd

WASHINGTON UNIVERSITY IN ST. LOUIS

George Warren Brown School of Social Work

Dissertation Examination Committee:
J. Curtis McMillen, Chair
Enola K. Proctor
Ramesh Raghavan
Melissa Jonson-Reid
Bradley Stoner
Barton Hamilton

THE PURSUIT OF ACCREDITATION IN CHILDREN'S MENTAL HEALTH CARE:
MOTIVATIONS, EXPERIENCES, AND PERCEPTIONS

by

Madeline Y. Lee

A dissertation presented to the
Graduate School of Arts and Sciences
of Washington University in
partial fulfillment of the
requirements for the degree
of Doctor of Philosophy

May 2010

Saint Louis, Missouri

ABSTRACT OF THE DISSERTATION

The Pursuit of Accreditation in Children's Mental Health Care:

Motivations, Experiences, and Perceptions

by

Madeline Lee

Doctor of Philosophy in Social Work

Washington University in St. Louis, 2009

Professor J. Curtis McMillen, Chairperson

Accreditation is a growing, worldwide phenomenon and thousands of mental health organizations spend considerable amounts of money and resources towards achieving and maintaining accreditation. Despite its widespread use, the empirical and theoretical literature on accreditation is sparse. This study is the first step towards examining accreditation's potential as an organizational intervention to improve the quality of mental health services.

Using a mixed methods multiple case study design, this exploratory study aimed to 1) understand agencies' motivations to pursue accreditation, 2) explore agencies' experiences with the accreditation process, 3) identify mental health care workers' perceptions of how the accreditation process may improve mental health service delivery and outcomes. These issues were explored with five children's mental health agencies that had recently undergone or were undergoing the Council on Accreditation (COA) process. Multiple sources of data were collected at each agency, including qualitative

data from in-depth interviews and focus groups, as well as quantitative survey data from employees, a review of documents related to accreditation, and limited observations of the agencies.

Agencies discussed various factors that motivated their decision to pursue accreditation, including policies recognizing accreditation, funding opportunities, and agencies wanting to professionalize and gain distinction. Regarding the accreditation experience, each agency took different approaches to delegating the work and the length of the process varied according to the recommendations from COA. The self-study was the most time consuming part and most employees described a positive and helpful site visit. Related to the employees' perceptions of the impact of accreditation, meeting COA's requirements for quality improvement efforts was a major focus, though what this entailed varied. It was not always prominent if the accreditation process improved client outcomes. Employees also shared about how accreditation increased or decreased morale at their agency.

These findings have implications for how accreditors engage agencies and how agencies engage employees in the accreditation process. There are additional implications for policies regarding accreditation, further theory development about how accreditation is meant to work, and future research to build evidence for accreditation. More research is needed to maximize accreditation's potential to improve services and outcomes for the millions served by accredited organizations.

ACKNOWLEDGEMENTS

you Stace for cheering me on through every up and down, for being such a source of comfort. Thank you friends at Westminster Pres for providing me with a place where I could regain my strength and feel replenished.

I am indebted to many other mentors and colleagues who have shaped the road that has led me here: Linda Levine for believing in me from the very beginning; the late Professor Albert Boime for teaching me that "the study of imagery will show that we are not yet too fallen or depraved to reform the world in the name of suffering humanity"; Dr. Stuber, Debby Seacord, and Lisa Libman-Mintzer for giving me an early opportunity to do research; Arlene Goldsmith and Linda Meaney for giving me the chance to spend a summer in New York City that would change my life; Dr. Leap, Wen-Jui Han, and Marcy Carlson, my first social work teachers who encouraged my pursuit of this journey; and my colleagues and mentors at Hollygrove for reminding me what it means to love what we do. This was all inspired by the children of Hollygrove who shaped my work and my heart.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE: OVERVIEW OF ACCREDITATION

Accreditation is a growing, worldwide phenomenon (Braithwaite et al., 2006). Everything from hospitals to tree care companies can be accredited and millions of people rely on accredited institutions everywhere from Australia to Zambia. As a formal evaluation of an organization against accepted criteria or standards (Council on Accreditation, 2008b), accreditation has become a widely accepted signal of quality, credibility, and trustworthiness. In fact, the word accredit comes from the Latin word for trust, *credito* (Alstete, 2007). Accreditation has spread to a range of industries and fields, including mental health care.

Both the Institute of Medicine (IOM, 2006) and the Surgeon General (U.S. Department of Health and Human Services, 1999) have cited accreditation as an organizational intervention with the potential to improve the quality of our nation's ailing mental health service system. Today, three large bodies—the Joint Commission, the Council on Accreditation (COA), and the Commission on Accreditation of Rehabilitation Facilities (CARF)—accredit thousands of mental health organizations. Accreditors tout the accreditation status they bestow as a signal of quality, credibility, and trustworthiness, yet the empirical and theoretical literature on accreditation is amazingly sparse. Studies show only moderate evidence for accreditation's merit (Cerqueira, n.d.; Mays, 2004). Most of the studies on accreditation are from health care, and only a few inquiries are in other fields. In addition, none of the literature uncovers how agencies experience the accreditation process, nor has it conceptualized accreditation theoretically (Brommel, 2006; Nichols, 1980).

Accreditation may be a leverage point and means for quality improvement, but how is the accreditaiton process meant to work? According to Blalock (1968), there is often times a gap between theory and research. Currently, accreditation does not rely on theory but relies on reputation and popularity instead. Theory-building could help improve the quality of research on accreditation. This study takes steps towards building a theory of accreditation by generating testable hypotheses for more empirical research to move the field forward.

The first chapter provides an overiew of COA accreditation, including its history and evolution, what it entails, and its costs. Chapter two reviews the current empirical evidence on the impact of accreditation from a range of fields, since the literature on COA accreditation of mental health services is small and limited. Next, chapter three examines the theories that inform this study and puts forward a conceptual framework to guide the study. Chapter four outlines the mixed methods case study research design and methodology that was employed for this study. Results from each individual case study and a cross case analysis are presented in chapter five. Chapter six concludes with a discussion of key findings, along with implications for COA and other accreditors, agencies, policy, theory development, and further research.

Key Research Aims

Using mixed methods, this study builds towards a theory of accreditation with testable hypotheses by exploring children's mental health agencies' experiences with accreditation. The aims of this study include:

Aim 1: To understand agencies' motivations to pursue accreditation and specifically, accreditation with COA. What were their reasons for seeking accreditation? What do they hope accreditation will accomplish? This study will explore if various reasons for pursing accreditation could affect the impact of accreditation at the agencies.

Aim 2: To explore agencies' experiences with the COA accreditation process. The study poses several questions toward this aim. What are the challenges, burdens, and costs they faced during the process? What are the unintended consequences of the accreditation process that may hinder quality service delivery? How did they benefit, and what did they learn and implement because of the accreditation process? In what organizational context is accreditation most effective at creating or ensuring quality? The answers to these questions will begin to reveal the impact of accreditation.

Aim 3: To identify mental health care workers' perceptions of how the accreditation process can improve mental health service delivery and outcomes. The study asks the question, what are the mechanisms and standards that may be leading to service improvements during the accreditation process? This will generate hypotheses regarding how accreditation can meaningfully affect quality of care to improve consumer outcomes.

Accreditation is an organizational intervention that has the potential to improve existing approaches for the prevention, treatment, and cure of mental illness. The findings from this study can increase our understanding of *how* undergoing the accreditation process can improve quality of care to change consumers' lives.

Background and Significance

Statement of the Problem

Too many children are not receiving the quality mental health care they need and deserve. As an example of the quality problem in mental health care for our most vulnerable youth, a recent U.S. General Accountability Office (US GAO, 2008) report found that many of the more than 200,000 youth who seek help from residential treatment facilities were at high risk for maltreatment and death while in care due to gaps in oversight by states. Although states license and monitor residential facilities, they reported an inability to consistently conduct yearly onsite visits, and licensing standards did not consistently address critical issues such as suicide and inappropriate use of seclusion and restraint (US GAO, 2008). The GAO found that accreditors did not always inform the state if a facility's accreditation status was suspended or limited, yet states often look to accreditation as the third party guarantor to provide oversight and regulate services (US GAO, 2008).

Poor quality children's mental health care can lead to negative consequences. Children with mental health issues are more like to rely on restrictive and costly services, such as juvenile detention, residential treatment, and emergency rooms (Almgren &

Marcenko, 2001; Cooper & Masi, 2007; Masi & Cooper, 2006; Pottick, Warner, & Yoder, 2005; U.S. House of Representatives Committee on Government Reform, 2004). In addition, mental health care for many children may fall short of adherence to quality indicators such as service linkage, parental involvement, use of evidence-based psychological treatment, and patient protection from abuse or suicide (Zima et al., 2005). Too many children with mental health needs are struggling to succeed and the quality of services needs attention in order to improve their outcomes and life chances.

As a formal evaluation of an organization against accepted standards that are recognized as a model of excellence (COA, 2008b), accreditation may have the potential to tackle these quality issues and make a difference. The COA accreditation process entails demonstrating implementation of the accreditation standards based on a self-study by the agency, a site visit by COA's reviewers, a report of recommendations, and a final report along with an accreditation decision. Accreditors purport that accreditation is designed to improve quality, but we do not know *if or how* it improves quality.

Evolution and Prevalence of Accreditation

The accreditation concept is over a century old. Accreditation systems first emerged in the field of education as a means for standardizing variability in the growing number of colleges in the nineteenth century (Selden, 1960). Although accreditation in health care developed independent of accreditation in education, the need for standardization was a common theme. In 1951, the Joint Commission on Accreditation of Hospitals (JCAH) (Roberts, Coale, & Redman, 1987), later known as the Joint

Commission on Accreditation of Hospital Organizations (JCAHO) and known today as the Joint Commission, was established to address standards of quality health care.

Accreditation in social services and mental health care evolved from the concepts of quality assurance and quality improvement in medicine and health care (Edmunds, Frank, Hogan, McCarty, Robinson-Beale, & Weisner, 1997). In response to growing concern in the 1960s regarding quality of care in other types of health care organizations, JCAH expanded its accreditation programs to include behavioral health care, such as community mental health programs, chemical dependency, and mental retardation/developmental disabilities services (Roberts et al., 1987; The Joint Commission Behavioral Healthcare, n.d.) While expanding the scope of its accreditation programs, JCAH provided administrative support to Commission on Accreditation of Rehabilitation Facilities (CARF) (Edmunds et al., 1997) when it was established in 1966 (CARF Who We Are, n.d.). CARF began to accredit community-based rehabilitation programs for the chronically and persistently mentally ill, as well as other mental health and alcohol and drug programs (Edmunds et al., 1997).

While JCAH and CARF originated from medical and rehabilitation models and later expanded to accredit behavioral health care and social services, COA was founded as an accreditor of child-serving social services in 1977. COA began in 1975 when the Family Service of America (FSA) (now the Alliance for Children and Families) and the Child Welfare League of America (CWLA) jointly proposed to develop a national accrediting body for children and family services (Carman, 1996) in order to distinguish agencies eligible for funding, third party insurance reimbursement, and to determine the

quality of services delivered. COA provided children and family services an alternative to the medical model of accreditation.

The Joint Commission, CARF, and COA are the three largest accreditors of mental health care today. In 2006, the Joint Commission accredited 14,475 health care organizations in the United States and 1,811 of those organizations were behavioral health care providers (J. Walsh, personal communication, August 27, 2007). CARF accredits more than 5,000 providers that serve almost six million people in the United States, Canada, Western Europe, and South America (CARF, 2008). In 2007, COA accredited or was in the process of accrediting more than a total of 1,800 private and public organizations that serve more than seven million individuals and families in the United States, Canada, Bermuda, Puerto Rico, England, and the Philippines (COA About Us, n.d.).

COA's mission underscores its work in the social services and improving outcomes: "COA partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards" (COA About Us, n.d.). In a larger context, accreditation has an important role in defining professions because it affects the education of professionals as well as the services delivered by the professionals. According to Marsh (2003), professional associations, accrediting organizations, regulators, insurers, and academic institutions shape the social work knowledge base. For example, standards set by CSWE define social work education and COA accreditation can define how social workers deliver services. In this way, accreditation can help legitimize a profession (Marsh, 2003), yet little is known about accreditation's ability to improve quality of services.

This study concentrated only on COA accreditation because it examined children's mental health agencies and COA is the only accreditor that was founded to specifically focus on child-serving organizations. Also it would be difficult to account for the variations in accreditation processes among the three accreditors. For example, although some standards address similar issues across accreditors, such as leadership, governance, and quality improvement, the Joint Commission and CARF both do not require agencies to submit self-studies. Thus, this study focused on one accreditor, COA, and various children's mental health services that it accredits. Children's mental health agencies in this study provided one or more of the following services and responded to those service standards as defined by COA: outpatient mental health services, day treatment, residential treatment, therapeutic foster care, group living services, counseling, support, and education services, family preservation and stabilization services, emergency shelter services, crisis response, wilderness adventure-based therapeutic outdoor services, social development, or child and family development services. It is hoped that future studies will build on this exploration to examine other accreditors and compare similarities and differences to the present study.

Critical Components of COA Accreditation

The critical components of COA accreditation, including the accreditation **standards**, **process**, and **costs** are summarized in Table 1.1 and then discussed in further detail. On average, it takes 12 to 14 months for an agency to complete the initial COA accreditation process.

Table 1.1 Critical Components of COA Accreditation

Standards	**Elements of the Standards**	Administration and management standards Service delivery administration standards Service standards
	Standards Development	Evidence-informed
	Standards Revised	Revised every 4 years with periodic updates posted on their website
Process	**Self-Study**	Organization is required to submit a self-study
	Site Visit	Site visit includes tour, interviews, and document review
	Peer Reviewers' Compensation	Volunteers
	Peer Reviewers' Experience and Training	2 day training certification from COA A graduate degree and at least five years of continuous senior management experience or undergraduate degree and ten (10) years continuous senior management experience. Recommendation letter from an active COA Team Leader, Peer Reviewer, Accreditation Commissioner or representative from one of COA's Sponsoring or Supporting Organizations.
	Peer Reviewers' Approach	The role of the peer reviewer is to determine the organization's implementation with the application of COA standards.
	Rating System	Implementation of standards: 1= full implementation/outstanding performance 2=substantial implementation/strong performance 3= partial implementation/concerning performance 4= unsatisfactory implementation and performance
	Accreditation Decision	Successful accreditation Deferral of accreditation Denial of accreditation
	Accreditation Cycle	4 year
	Maintenance of Accreditation	Organization is required to submit an annual Maintenance of Accreditation (MOA) report to COA in each of the first three years following (re)accreditation. The MOA is a self-reporting tool that apprises COA of critical events and significant occurrences.
Costs	**Cost for Standards**	Free, available on-line
	Cost for Application	$750 for new applicants only
	Cost for Accreditation	Sliding scale based on an organization's gross annual revenue, minus pass through funds, in the year preceding application or commencement of the reaccreditation process. Organizations that are members of one of COA's Sponsoring Organizations receive 25% discount.
	Cost for Site Visit	$2,000 per peer reviewer for a two-day on-site review, plus $425 per day times the number of reviewers for each additional day, but the needs vary depending on the size of the organization and number of programs eligible for COA accreditation
	Cost for Maintenance of Accreditation	$400 annual fee

Agencies are required to respond to COA's **accreditation standards**, which consist of three categories: administration and management, service delivery administration, and service areas (Table 1.2). According to COA, Administration and management practices are designed to promote sound organizational operations and accountability. Service delivery administration standards intend to address practices related to the administration of service, such as administrative and service environment, behavior support and management, client rights, and training and supervision. Specific service area standards are recommended practices for service areas, such as residential treatment or day treatment. Each agency seeking accreditation is required to address the full administration and management standards and applicable service standards services (COA, 2008l).

Each of COA's standards has three components that build upon each other: purpose, core concept, and practice standards. Table 1.3 provides an example of how the standards are organized.

Table 1.2 COA Accreditation Standards

Administration and Management
Ethical Practice
Financial Management
Governance (for private agencies) or Administration and Management (for public agencies)
Human Resources Management
Performance and Quality Improvement
Risk Prevention and Management
Network Administration*
Service Delivery Administration
Administrative and Service Environment
Behavior Support and Management
Client Rights
Training and Supervision
Specific Service Areas
Adoption Services
Adult Day Services
Adult Guardianship*

Adult Protective Services
Case Management
Child and Family Development and Support Services
Child Protective Services
Crisis Response and Intervention Services
Counseling, Support, and Education Services
Day Treatment Services
Domestic Violence Services
Early Childcare and Development Services
Employee Assistance Services and Programs
Family Preservation Services
Financial Education and Counseling Services (formerly Financial Management and Debt
Counseling Services)
Foster Care Services
Group Living Services
Home Care and Support Services
Juvenile Justice Case Management Services*
Juvenile Justice Corrections Services*
Juvenile Justice Day Services*
Kinship Care Services
Immigration and Refugee Resettlement Services
Intercountry Adoption
Opioid Treatment Programs
Out-of-School Time Services
Outdoor Activities Supplement
Outpatient Mental Health Services
Outreach Services
Pregnancy Support Services
Psychiatric Rehabilitation Services
Residential Treatment Services
Respite Care
Services for Individuals with Developmental Disabilities
Services for Substance Abuse Conditions
Shelter Services
Social Development and Enrichment Services fro Children and Youth
Supplement for Developmental Disabilities Programs
Supported Community Living Services
Vocational Rehabilitation Services Skill Development Training
Volunteer Mentoring Services
Wilderness and Adventure-Based Therapeutic Outdoor Services
Workforce Development and Support Services
Youth Independent Living Services

*Agencies in this study did not respond to this standard since it was added after completion of
data collection for this study.

Table 1.3 Organization of COA Standards: An Example from the Residential Treatment
Standards

Purpose Standard
Residential Treatment
Residential Treatment Services are delivered according to an articulated philosophy that ties individual needs to specific interventions and education, and to achievement of stated goals, such as gains in measurable skills, increased productivity and pro-social behavior, improved functioning, and a stable living arrangement in the community.

Core Concept Standard
Residential Treatment 2: Family Connections
The resident, family, and organization work together to determine and maintain an optimal level of family connection and involvement in treatment activities.
Practice Standard
Residential Treatment 2.01: Family Connections
The organization helps every resident to:

The organization helps every resident to:
a.   express the nature of family connection desired;
b.   resolve conflicts in family relationships;
c.   identify family strengths that help members meet challenges;
d.   cope with family separation;
e.   maintain relationships with family members through planned visits and shared activities;
f.   participate in family and neighborhood activities; and
g.   prepare for return to the family, if appropriate.

The purpose standard "states achievable outcomes for the area of practice and expresses the overall aim of the practices included in a section" (COA, 2008c). This is the overarching idea of the standard. Each standard then is comprised of sub-sections that begin with a core concept standard. "Core concept standards describe in measurable terms program components that support the program's purpose. The organization's implementation of all core concepts contributes to the achievement of the purpose standard" (COA, 2008c). Building on the core concepts, the practice standards "contain detailed practices that contribute to meeting the core concept standards, and, in turn, the purpose standard. Practice standards are the most specific standards for which the organization shows evidence of implementation" (COA, 2008c).

COA currently requires all agencies to meet 11 administration and management and service delivery administration (network administration standards regarding delivering an integrated network of services to ensure optimal access, quality of care, and consumer satisfaction were recently added, and thus did not apply to the agencies in this study) purpose standards, 73 core concept standards, and 266 practice standards. Many of

12

the practice standards also consist of several requirements. In addition, the organization is required to meet applicable service standards for the agency's programs. For example, a residential treatment program has an additional 19 core concept standards and 92 practice standards to meet.

COA states that the development of their standards is guided by three sources: information gathered formally, through expert panels and advisor work groups, informal discussion with human service organizations about how the standards are implemented in a range of circumstances, and reviews of published research and professional literature (COA, 2008e).

For the first time, COA has included selected reference lists of research that informs COA's standards on their website. COA describes this research as supporting "practices with evidentiary support, practices COA identifies as 'evidence informed'" (COA, 2008e). Although this may be COA's justification for their standards, their criteria for "evidence informed" are not explicit; they provide a list of articles, but no additional information is provided regarding how they were selected or used to inform the standards. COA anticipates that the reference lists of research will continue to grow and evolve as new practices develop and service delivery trends emerge (COA, 2008e). COA's standards are revised approximately every four years, and updates are posted on the website periodically.

Based on the standards, COA requires a **self-study** by agencies. This involves the submission of documentation, or what COA calls 'evidence', in response to the standards. Everything from emergency procedures to a performance quality and improvement plan is required to be submitted to show that the agency is implementing

the standards. It also requires agencies to write narratives in response to specific questions about organizational functioning and their programs as well as additional supporting documents, such as quarterly reviews and corrective action plans. The self-study generally results in several large binders full of documentation, but COA has recently implemented electronic self-studies where documents can be organized as files on CD ROMs.

Upon completion of the self-study, a **site visit** of the agency seeking accreditation is conducted by a team of COA peer reviewers. The site visit consists of program and facility observations, review of documents, and interviews with various stakeholders, including the CEO, board members, staff, and clients. The peer reviewers then write a report, usually including recommendations for changes. COA's peer reviewers are volunteers. They receive no monetary compensation and are reimbursed only for the expenses incurred related to the site visit (COA Peer Reviewer/Team Leaders, n.d.).

COA requires **peer reviewers** to have a graduate degree and at least five years of continuous senior management experience in fiscal management, organizational governance/leadership, clinical services, or quality improvement initiatives, or an undergraduate degree and 10 years of continuous senior management experience (COA Peer Reviewer/Team Leaders, n.d.). In addition, they need to submit a letter of recommendation from an active COA Team Leader, Peer Reviewer, Accreditation Commissioner or representative from one of COA's Sponsoring or Supporting Organizations. COA certifies peer reviewers upon completion of a two-day training.

Based on the self-study and on-site documents, as well as observations and interviews conducted during the site visit, the peer reviewers prepare a report, known as

the Pre-Commission Report (PCR). Using the following **rating system**, the reviewers

rate the agency on each standard.

        1= full implementation/outstanding performance
        2= substantial implementation/strong performance
        3= partial implementation/concerning performance
        4= unsatisfactory implementation and performance

In order to attain COA accreditation, an organization must receive "1" or "2" on all

purpose standards as well as "1" or "2" on all core concept standards. While an

organization can achieve accreditation with a "3" or a "4" rating on some practice

standards, these ratings cannot reflect a pattern of partial or unsatisfactory

implementation. The organization must also earn a "1" or "2" on all fundamental practice

standards (COA, 2007a). The agency is given 45 business days after the PCR is shared

with the agency to submit a response to the recommendations and improve on standards

rated as "3" or "4" before an accreditation decision is rendered. Depending on the

number and nature of the recommendations, this may not be enough time to address all

them. According to COA, agencies can be granted deferrals in accreditation decisions for

up to one year in order to provide the organization with an additional opportunity to

demonstrate implementation of/continuing performance with COA's standards (2007a).

There may be additional fees associated with extending the accreditation timetable.

      COA's **accreditation decisions** could result in successful accreditation, deferral,

or denial. If the organization is successful, COA accreditation is effective for four years

(A three-year cycle is available to organizations that participate in a network or other

entity that mandates it (COA, 2007a). Although the peer reviewers rate the organizations

on the standards, the accreditation decisions are made by the COA Accreditation

Commission based on the PCR prepared by the peer reviewers and the organization's

responses to the PCR. The Commission consists of peer review team leaders whose nominations are approved by COA's President/CEO. According to COA, "The Accreditation Commission reviews all documentation in a manner free from conflict of interest and without knowing the identity of the organizations under review." (COA, 2007a). COA's accreditation ratings, decisions, and rate of success are not readily available to the public.

To **maintain accreditation**, COA accredited agencies are to submit an annual Maintenance of Accreditation (MOA) report to COA in each of the three years following (re)accreditation. "The MOA is a self-reporting tool that apprises COA of critical events and significant occurrences, including changes in services, structure, personnel, and/or funding, and attests that the organization is continuing to implement COA's standards and is using accreditation as a catalyst for continuous quality improvement" (COA, 2007a). The Accreditation Commission reviews MOA reports and their decisions can result in probation, suspension, or revocation of accreditation.

In addition to the annual MOA report, COA accredited organizations are required to self-report, "as per required time frames", regarding other significant events such as, serious consumer injury or death, merger or acquisition, license revocation, opening or closing of programs, and change in CEO/Executive Director. Based on these self-reports, "COA's President/CEO has the authority to take immediate action to suspend or revoke the accreditation of an organization where (s)he is informed of conditions sufficiently serious to warrant such action" (COA, 2007a).

Despite these requirements, COA does not make information from maintenance of accreditation reviews available to the public, making it impossible for the public to

16

know about agencies' performance in between accreditation cycles. Agencies may not continuously improve and maintain quality of services up to COA's standards after successfully achieving accreditation.

Cost of COA Accreditation

Mental health agencies are investing substantial amounts of money, time, and other resources into accreditation efforts. It can cost several thousand dollars in accreditation fees alone, not including the costs associated with site visit preparation. Assembling the self-study, writing the required narratives, preparing all stakeholders for the site visit, responding to the PCR and making the necessary changes all take a significant amount of resources and time from agency staff.

COA's standards used to be available for purchase, but when the eighth edition was released in 2007, they were made available free of charge on a new website (www.coastandards.org). COA has an accreditation application fee of $750 for new applicants. In addition, the general accreditation fee (Table 1.4) is on a sliding scale based on an organization's gross annual revenue, minus pass through funds, in the year preceding application or the start of the reaccreditation process. A 25% discount is available to organizations that are members of one of COA's Sponsoring Organizations. For the site visit, COA charges $2,000 per peer reviewer for a two-day on-site review, plus $425 per day times the number of reviewers for each additional day. The needs for the organization may vary depending on the size of the organization and number of programs eligible for COA accreditation. The annual fee for COA's maintenance of accreditation is $400.

Table 1.4 COA Accreditation Fees for Calendar Year 2008 (COA, 2008j)

Agency Revenue	Accreditation Fee per Cycle
500,000	6,720
1,000,000	8,590
1,500,000	9,924
2,000,000	10,991
2,500,000	11,926
3,000,000	12,193
4,000,000	12,859
5,000,000	13,393
7,000,000	14,594
10,000,000	16,462
15,000,000	19,397
20,000,000	22,464
25,000,000	25,399
30,000,000	32,818
35,000,000	35,886
40,000,000	38,955
50,000,000	44,825
60,000,000	50,961
70,000,000	56,830
80,000,000	62,833
90,000,000	68,970
100,000,000	74,839

Given the burden associated with achieving accreditation, one hopes that the reward in improved quality of services is worth it, yet we do not know *why* agencies seek accreditation or *how* the accreditation process can spur quality improvement.

CHAPTER TWO: EMPIRICAL EVIDENCE ON ACCREDITATION

Although accreditation is over a century old and a world-wide phenomenon, there is little empirical research supporting its use as a tool for quality improvement. With a limited number of studies that specifically focus on COA accreditation and/or accreditation in mental health, this chapter draws upon research from various fields, such as health care, child care, business, and education. As a result, this chapter reviews studies involving many different accreditors and accreditation programs from four countries. In addition, the studies employed a range of research designs and very few shared outcomes. These issues made it exceptionally challenging to craft a cohesive narrative that succinctly synthesized the research on accreditation.

A table summarizing each empirical study is presented (Table 2.1). This table may be the most useful way to examine the evidence; offering an opportunity to consider the studies individually. Alternatively, this chapter provides a narrative synthesis of key findings from studies that examined COA accreditation and/or mental health care. Lessons learned from various fields will be highlighted. This chapter will conclude with a discussion on methodological issues in the empirical research.

Search Strategy

Reviews and individual empirical studies were identified by searching the following databases: Academic Search Premier, Social Work Abstracts, Sociological Abstracts, MEDLINE (NIH/pubMED), Social Services Abstracts, Social Sciences Citation Index (Web of Science), and PsycINFO. Combinations of the following keywords were used in the search: accreditation, outcome(s), impact(s), effect(s), Joint

Commission, Commission on Accreditation of Rehabilitation Facilities, and Council on

Accreditation. Other studies were found by contacting COA, conducting additional

searches on the internet, and from articles' (including review articles on accreditation)

reference lists. Inclusion criteria specified that the empirical studies focused on the

impact of accreditation on indicators of quality as dependent variables. The search

resulted in 28 individual empirical studies that met the criteria.

Search Results

The search yielded studies from various fields, including health care, education,

business, social services, and mental health care. The studies also employed various

research designs. This section will summarize which articles were from which fields and

then will critique the research designs and summarize their main findings.

Most of the studies (11 our of 28) were on hospital accreditation; six on JCAHO

(Chen, Rathmore, Radford, & Krumholz, 2003; Freund & Lichtenberg, 2000; Frasco,

Sprung, & Trentman, 2005; Hadley & McGurrin, 1998; Miller et al., 2005; Moffett &

Bohara, 2005), and five on international hospital accreditation—one on the National

Agency for Healthcare Accreditation and Evaluation in France (Pomey,

Contandriopoulos, Francois, & Bertrans, 2004), one on the Council for Health Services

Accreditation for Southern Africa (COHSASA) (Salmon, Heavens, Lombard, & Tavrow,

2003), one on hospital accreditation by the Ministry of Public Health in Lebanon (El-

Jardali, Jamal, Dimassi, Ammar, & Tchaghchaghian, 2008), and two on the Australian

Council on Hospital Standards (Duckett, 1983; Duckett & Coombs, 1981). Several others

were also in the health care arena; one each on National Committee for Quality

Table 2.1 Empirical Studies on the Impact of Accreditation

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
Abuhamad et al., 2004	American Institute of Ultrasound in Medicine (AIUM) accreditation	Compared initial accreditation and reaccreditation scores of 82 ultrasound practices Used 97 recently accredited practices as a control group	Compared mean and median difference in accreditation and reaccreditation score using a paired t test. To control for time, initial accreditation scores and reaccreditation scores were compared with recently accredited scores with independent t test or Wilcoxon rank sum test as appropriate.	AIUM accreditation and reaccreditation scores	Accreditation scores significantly improved at reaccreditation three years later. Reaccreditation scores were also significantly higher than scores of the recently accredited control group.
Adams, 2005	Council for Accreditation of Counseling and Related Educational Programs (CACREP)	Two samples of National Counselor Examination (NCE) score, n=977 and n=959	ANOVA	Pass/Fail on NCE	Test takers that attend a CACREP accredited program scored statistically significantly higher on the NCE than test takers that did not attend a CACREP accredited program
Beaulieu & Epstein, 2002	National Committee for Quality Assurance (NCQA)	Healthcare Effectiveness Data and Information Set (HEDIS): non-accredited (n=69), accredited (n=170), denied (n=11), fully accredited (n=98) Patient reports: non accredited (n=83),	Linked data from NCQA, HEDIS, patient-reported information, and longitudinal data on plan enrollment T test on mean HEDIS scores Fisher-Irwin exact tested whether the "incidence	HEDIS measures, patient-reported measures of quality, health plan enrollment changes	Accredited plans had statistically significant higher HEDIS scores, but a substantial number of plans in the bottom decile of quality performance were accredited. No statistically significant difference between accredited and non-accredited plans on patient-reported measures of quality and satisfaction.

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
		accredited (n=148), denied (n=19), fully accredited (n=78)	rates" of accreditation in the top and bottom deciles of performance were significantly different from rate of accreditation in overall sample.		
Center for Substance Abuse Treatment (CSAT), 2004	CARF JCAHO Opioid treatment	172 opioid treatment programs, 144 followed-up	Not all data from statistical tests were reported. Pre and post test for sites undergoing accreditation and sites that delayed accreditation	Process and outcomes of accreditation Impact of accreditation on treatment Role of states under an accreditation system	All programs reported increases in patient capacity Staff retention increased more at experimental sites compared to control sites No effect on methadone diversion Experimental group offered more comprehensive services than sites in control group Accreditation influenced monitoring of patient outcomes and quality assurance systems
Chen et al., 2003	JCAHO	143,579 patients treated at 4, 221 hospitals (1,042 were not surveyed, 3,169 were JCAHO accredited)	Chi-square tests and ANOVAs were used to compare difference across hospitals Chi-square Cochrane-Armitage test was used to evaluate for linear trends in therapy and	Use of aspirin or beta blockers within 48 hours of admission, aspirin or beta blockers anytime during hospitalization Acute reperfusion therapy within 6 hours of admission	Although patients at nonsurveyed hospitals were less likely to receive aspirin and beta blocker, as well as acute reperfusion therapy, there was large variation in performance within JCAHO accreditation levels. Non-surveyed hospitals had higher mortality rates than accredited hospitals

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
			mortality rates associated with higher accreditation ranking	30-day mortality	and there was a trend towards higher mortality among conditionally accredited hospitals, but there was considerable variation in risk-standardized 30-day mortality rates within accreditation levels.
Demetriades et al., 2005	American College of Surgeons (ACS) trauma center accreditation	12,254 patients from the National Trauma Data Bank maintained by the ACS to compare outcomes by level 1 and level 2 ACS accreditation (Level 1 is the highest level of accreditation, based on nurse/surgeon availability and protocols)	Logistic regression	Mortality, intensive care unit length of stay, and severe disability at discharge Controlling for age, gender, injury mechanism (blunt or penetrating), injury severity score, and hypotension on admission	Mortality in level 1 trauma centers was significantly lower than in level 2 trauma centers (adj OR=0.81, p=0.004) or all other centers (level 1, 2, 3, 4, non-accredited) (adj OR=0.82, p=0.000) Overall, level 1 centers had significantly better functional outcomes at discharge. Volume of severe trauma did not have any effect on mortality in level 1 or level 2 centers.
DiRusso et al., 2001	ACS trauma center accreditation	One trauma center that started to prepare for ACS accreditation in early 1996 and completed the process in 1998	Pre and post accreditation data were analyzed using student's t test for continuous variables and Mann-Whitney U test for discrete variables. Chi-square was used to assess significant differences for dichotomous variables.	Pre-hospital management and transport, emergency room management, hospital management, injury mechanisms, and outcomes and complications, abbreviated Injury Scale, Injury Severity Scale, Revised Trauma Score, Trauma and Injury Severity Score (TRISS), and Glasgow Coma Scale.	There was a significant decrease in mortality when comparing 1994 and 1998 rates, both risk-adjusted and non-risk-adjusted. Average length of stay significant decreased, which in turn led to a cost savings of $7.4 million for the 1 year period 1994 vs. 1998. These cost savings helped alleviate the expenditures for system improvement, such as increasing number of staff.
Duckett, 1983	ACHS	Stratified random sample of 23	No statistical tests were performed	Administration and management	Accreditation had the most impact on improving nursing services

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
		hospitals	Compared hospitals that were surveyed, to be surveyed, and not applied accreditation	Medical staff organization Review systems Organization of nursing services Physical facilities and safety Hospital role definition and planning	(documentation and revision of procedures) and physical facilities and safety (installation of fire alarms, more accessible fire fighting equipment) Accreditation also improved communication
Duckett & Coombs, 1981	Australian Council on Hospital Standards (ACHS)	47 accreditation reports 23 hospitals that were surveyed by ACHS, applied for survey or intended to apply for survey, or in control group of hospitals that had not applied for survey	Number of recommendations in accreditation reports were counted and categorized. Comprehensive, semi-structured interviews with Directors of Nursing and other senior personnel in hospitals surveyed by ACHS	Number and nature of recommendations in accreditation reports Interviews captured baseline data related to what were normal hospital practices prior to applying for survey; what changes, if any, had taken place, particularly changes that took place associated with the accreditation process.	Nursing services received an average of more than 5 recommendations per report, which reflected the importance of these services. Most recommendations were regarding nursing administration and administrative procedures and were not related to any of the standards. Most non-standard recommendations were pharmacy related items and environmental safety issues. Some interviewees expressed that the nursing staff maximized the use of accreditation for change and reform. Accreditation helped formalize documentation and revision of procedures.
El-Jardali et al., 2008	Lebanese Ministry of Public Health hospital accreditation	59 hospitals that were successful in the accreditation process	Cross-sectional survey of nurses Surveys included 9 scales and subscales that were rated on a 5-	Nurses' perception of improvement in quality of care as a result of hospital accreditation (Quality Results)	Overall, nurses perceived an improvement of Quality Results on hospitals as an outcome of accreditation. The general trend was that the large

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
			point Likert scale ranging from one for strongly disagree to 5 for strongly agree. ANOVA for comparing hospitals by size Principal components factor analysis with orthogonal rotation Quality Results (dependent variable) was regressed on the perceived contributing factors that can explain change in quality of care (independent variables)	Perceived contributing factors that can explain changes in quality of care (Leadership, Commitment and Support, Strategic Quality Planning, Quality Management, Human Resource Utilization, Use of Data, Accreditation) Demographics (gender, age, educational qualifications, occupational category and years of experience) Size of hospitals (small <100 beds, medium 100-200 beds, large >200 beds)	hospitals had lowers scores, slightly higher for small hospitals, and highest for medium-sized hospitals. The exceptions were the scale on Quality Results and the subscale on Benefits of Accreditation, which were highest for the small-sized hospitals. Predictors of better quality results were leadership, commitment and support, use of data, quality management, staff involvement, and hospital size. Lebanese hospitals had been implementing their own quality improvement initiatives before accreditation, thus narrowing the room for improvement for larger hospitals. Also, the accreditation standards were designed for poor performing small and medium-sized hospitals, thus leaving more room for improvement for smaller hospitals since accreditation was newer to them.
Frasco et al., 2005	JCAHO	1083 patients (541 patients before JACHO pain initiative, 541 patients after JCAHO pain initiative)	Chi-squares Wilcoxon's ranked sum test Hodges-Lehmann method	Postoperative dose of opiates Post-anesthesia care unit (PACU) recovery time Use of patient controlled analgesia (PCA) Frequency and nature of use of antiemetics Use of naloxone	Increased use of opioids for comparable types of surgeries between the two periods. This increase was not associated with prolonged PACU length of stay

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
Freund & Lichtenberg, 2000	JCAHO	204 hospitals with both JCAHO Hospital Performance Reports and data from the Nationwide Inpatient Sample from the Hospital Cost and Utilization Project	Multiple regressions	Mortality Rates of surgical/medical misadventures Adverse drug reactions Length of stay	Probability of surgical/medical misadventures, adverse drug reactions, or death all increased as the JCAHO score increased. Higher JCAHO scores were associated with lower lengths of stays.
Hadley & McGurrin, 1988	JCAHO	216 state psychiatric hospitals (14 hospitals were JCAHO accredited, 41 had HCFA certification, 123 had both JCAHO and HCFA accreditation, and 38 had neither)	Multiple regressions	Average cost per patient Per diem bed cost Total staff hours per patient Clinical staff hours per patient Percent of staff hours provided by medical staff Bed turnover Percent of beds occupied	Although hospitals with any type of accreditation or certification were more likely to have higher values on specific indicators of quality than hospitals without any accreditation or certification, differences in median values were too small to substantiate any claim to overall superior quality of care of JCAHO or HCFA certified hospitals.
Hazard et al., 2002	COA Foster care services	6 organizations: 3 COA-accredited and 3 non-accredited	Matched subjects design Data gathered from questionnaires, interview and review of organizations documents No statistical methods used	Organizational functioning, which included: Risk management practices, performance evaluation, correction action processes, internal quality monitoring, stakeholder participation, case record review, outcomes measurement, feedback mechanisms, consumer satisfaction, personnel satisfaction, and service specific processes	Only the 3 accredited organizations demonstrated implementation of risk management, performance evaluation, and corrective action processes. There was no clear pattern of difference between accredited and non-accredited organizations in internal quality monitoring, stakeholder participation, case record review, outcomes measurement, feedback mechanisms, consumer satisfaction, personnel satisfaction or service specific process.

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
Heras et al., 2002	ISO 9000 quality management systems accreditation	400 accredited firms, 400 non-accredited firms from the Ardan database in Spain	Longitudinal methodology with control group over a five year period. Compared the sales and profitability of firms, pre and post accreditation. Non-accredited firms for control group.	Actual sales Profitability	There was no evidence of improved performance after accreditation in the 400 accredited firms studied. Authors concluded that superior performance of accredited compared to non-accredited firms was due to firms with superior performance having a greater propensity to pursue ISO 9000 accreditation.
Kassebaum et al., 1997	Liaison Committee on Medical Education (LCME)	Examined the influence of accreditation on education and reform in U.S. medical schools by reviewing 90 schools with LCME accreditation between July 1992 and June 1997	Used LCME survey databases and site visit reports No statistical methods used	Substantive change was defined as centralizing the design and management of the curriculum, as well as one more of the following reforms: integrating basic and clinical science instruction and/or conversion to interdisciplinary courses; implementing methods of active, small-group, independent, and hypothesis-based learning; and substantially increasing student's exposure to ambulatory and primary care.	Educational shortcomings were identified in 61 of 90 medical schools coming up for accreditation surveys during 1992 to 1997. On those occasions, 34 of the 61 schools had instituted reforms or were on the verge of doing so. 15 schools also implemented reforms with the help of foundation awards. In some instances, it was not possible to differentiate the influence of the LCME as a force for educational reform from the incentives for change created by national foundations.
Mazmanian et al., 1993	CARF cognitive rehabilitation therapy (CRT)	252 health-injury rehabilitation facilities (74 CARF-accredited, 178 non-accredited)	Survey of facilities Chi-square differences between CARF accredited and non-	Education and training options, general expense for educational training, general learning needs of clinical	No statistically significant differences between CARF-accredited and non-accredited facilities except the CRT approach. CARF-accredited facilities were more likely use combined

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
			accredited CRT	staff, general Approaches to CRT Education/training in CRT Academic background of practitioners in CRT Expense for training in CRT	approaches, including 1:1, group, and home-based therapy.
Miller et al., 2005	JCAHO	2116 JCAHO accredited hospitals in 1997-1999	Principal components analysis to identify Agency for Healthcare Research and Quality Inpatient Quality Indicators (AHRQ IQI) and Patient Safety Indicators (PSI) factors Regression of IQI and PSI factors on JCAHO scores ANOVA of JCAHO accreditation groupings and IQI and PSI	AHRQ IQI and PSI performance	No significant relationship between JCAHO scores and IQI or PSIs Most hospitals had high JCAHO scores despite variation in IQI and PSI performance
Moffett & Bohara, 2005	JCAHO	10,810 cases from 453 hospitals from Healthcare Cost and Utilization Project's Nationwide Inpatient Sample from 1995 through 1997	Random-effects panel Poisson models Chi-square	Quarterly count of death that occurred for inpatient stays Compliance with JCAHO full survey performance areas over time, including administration, management, and patient care	A better patient care JCAHO survey score was correlated with better patient outcomes Administration and Management survey scores were correlated with worse patient outcomes Hospitals become more compliant as the survey approaches but this diminished after the survey was over

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
Pasquale et al., 2001	American College of Surgeons (ACS) accreditation	13,942 patients from 24 accredited trauma centers in Pennsylvania	Logistic regression	Survival of serious injuries	All levels of accreditation were associated increased survival rates
Pomey et al., 2004	National Agency for Healthcare Accreditation and Evaluation in France	1748 questionnaires, 67 interviews	Chi-squares for differences by gender ANOVA for differences by professions	Professionals' perception of self-assessment Conditions for implementation of change Redistribution of power Positioning of physicians Creation of social capital Change in practices and learning organization Hospital's relationship with its environment	Professionals viewed the preparations for accreditation as both bureaucratic and consensual Self-assessment provided those working in less prestigious structures within the hospital the opportunity to be heard, increasing communication, sharing of information, and greater service integration. Self-assessment helped develop values shared by professionals of the hospital and the creation an organizational environment which is more conducive to fostering better treatment of patients.
Salmon et al., 2003	Council for Health Services Accreditation for Southern Africa (COHASAS)	18 hospitals (9 in intervention group that underwent accreditation, 9 in the control group that did not undergo accreditation)	Chi-squares Correlations ANOVAs Pre and post test data for both intervention and control groups	Nurse perceptions of clinical quality Patient satisfaction Medical education of patients Medical record access and accuracy Medical record completeness Peri-operative notes completeness Labeling of ward stock medications	Accreditation impacted the quality indicators only marginally, with the exception of nurse perceptions. The other indicators showed no statistically significant differences between groups over time.

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
				Hospital sanitation	
Sampalis et al., 1995	ACS trauma center accreditation/ designation	158 patients treated in 1987 (pre-accreditation), 288 patients treated in 1993 (post-accreditation)	Multiple logistic regression	Mortality	Results showed significant higher mortality risk for the 1987 cohort
Simons et al., 2002	ACS trauma center accreditation	3 trauma centers immediately following designation	TRISS to compare outcomes in the one accredited center to the non-accredited centers	Excess/reduced mortality determined in the basis of actual versus predicted deaths.	Survival odds were statistically significantly better at accredited centers
Stratton et al., 2004	COA, JCAHO children's residential treatment	38 children's residential treatment facilities in Kentucky (8 COA-accredited, 17 JCAHO-accredited, 13 non-accredited)	Repeated-measures MANOVA to consider differences in treatment process and outcomes over the course of 3 years	Processes: Making the same mistakes across years (general and cultural competence) Counting new mistakes (general and cultural competence) Total number of mistakes over time (general and cultural competence) Outcomes: CBCL Client discharge Program discharge Children discharged with lower level of care	For general treatment processes, all facilities improved, although non-accredited facilities started out with more mistakes (not all p values were reported). There was an increase in total number of mistakes at non-accredited facilities at year 2 before a decrease in year 3, possibly due to the effect of Kentucky's own program reviews. For cultural competent processes, JCAHO-accredited and non-accredited facilities started with more mistakes than COA-accredited facilities. All facilities improved at year 2, but JCAHO-accredited facilities made more new mistakes and total number of mistakes at year 3. For CBCL outcomes, non-accredited and accredited facilities were statistically

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
					identical in all years. For client discharge outcomes, accredited facilities had more favorable client discharge outcomes than non-accredited facilities in year 2, but by year 3, they were all statistically identical. For program discharge outcomes, COA-accredited facilities were significantly better than non-accredited programs at year 1. By year 3, accredited and non-accredited facilities were statistically identical. For outcomes regarding children discharged to a lower level of care, both non-accredited and COA-accredited facilities showed improvement.
Volkwein et al., 2007	Accreditation Board for Engineering and Technology (ABET)	203 engineering programs	ANCOVA with multiple covariates to control for graduates' pre-college characteristics, program and institutional traits	Program changes Student experiences Learning outcomes	Program changes: No statistical results reported, but there was an increase in professional skills, communication, teamwork, and modern engineering tools. Student experiences: Statistically significant increase in 2004 versus 1994 in collaborative learning, instructor interaction and feedback, study abroad, international travel, design competition, involvement, society chapter involvement, and program diversity climate. Learning outcomes: Statistically significant increase in 2004 versus 1995

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
					competence in mathematics, science, and engineering skills, competence in project-related skills, competence in professionalism.
Whitebook et al., 1997	National Association for the Education of Young Children (NAEYC)	92 child care centers in three CA communities (23 successfully accredited, 32 participated in accreditation, but not successful, 37 did not seek accreditation)	Interviews regarding compensation, professional background, and cultural and linguistic sensitivity Observations, using the Early Childhood Environment Rating Scale (ECRES) and the Arnett Scale of Adult Involvement ANOVA Multiple regression	ECRES scores Sensitivity Harshness Detachment Adult to child ratio Staff turnover rate	Centers that achieved accreditation had higher overall classroom quality at beginning of the self-study and also showed greater improvement in quality compared to centers that participated in the self-study but did not become accredited. Nearly 40% of accredited centers were still rates of mediocre quality Accredited centers were not more likely than non-accredited centers to meet the linguistic needs of children who speak languages other than English Nonprofit status, higher wages paid to teaching staff, and the retention of skilled teachers, in combination with accreditation, were predictors of high quality centers.
Zellman et al., 1994	National Association for the Education of Young Children (NAEYC)	17 military installations (10 with at least one accredited center, 7 with no accredited centers) and 4 Major Commands	No statistical test performed Analyzed survey data from child development directors Interviews with military	Perceptions regarding the accreditation process and the effects of accreditation	Respondents reported mostly positive effects of accreditation, including higher staff morale and pride from increased prestige and recognition, better-defined program goals, more culturally diverse curriculum, and improved caregiving.

Reference	Accreditation Program(s)	Sample	Analytical Strategy	Quality Indicator(s)	Major Findings
			personnel, child development enter employees, parent users of care, and kindergarten teachers		

Assurance (NCQA) accreditation (Beaulieu & Epstein, 2002), cognitive rehabilitation therapy (Mazmanian, Krutzer, Devany, & Martin, 1993), and American Institute of Ultrasound in Medicine (AIUM) (Abuhamad, Benacerraf, Woletz, & Burke, 2004). Five others were on trauma center accreditation (Demetriades et al., 2005; DiRusso, Holly, Kamath, & Cuff, 2001; Pasquale, Peitzman, Bednarski, & Wasser, 2001; Sampalis et al., 1995; Simons et al., 2002).

Three articles focused on specialized accreditation in education. One was in medical education (Kassebaum, Cutler, & Eaglen, 1997), another in engineering (Volkwein, Lattuca, Harper, & Domingo, 2007) (Accreditation Board for Engineering and Technology) and another in counseling education (Adams, 2005) (Council for Accreditation of Counseling and Related Educational Programs).

Two studies were on child care accreditation by the National Association for the Education of Young Children (NAEYC) (Whitebook, Sakai, & Howes, 1997; Zellman, Johansen, & Winkle, 1994). Another study was on ISO 9000 accreditation of business firms (Heras, Dick, & Casadesus, 2002). Three studies were in social services (Center for Substance Abuse Treatment, 2004; Hazard, Pacinella, & Pietrass, 2002; Stratton, Reece, & Chesire, 2004). Only one of those three studies (Stratton et al., 2004) in the social services was on COA and JCAHO accreditation of mental health care (children's residential treatment) but it was not published. Another one of those three studies focused on COA's foster care accreditation (Hazard et al., 2002), but it was also not published and was accessed by contacting COA.

The studies also employed various research designs that had strengths and limitations. Among these studies, only two were randomized control trials; one was on

34

opioid treatment programs (CSAT, 2004) and the second was on accreditation of

hospitals in South Africa (Salmon et al., 2003). Salmon et al.'s (2003) study on South

African hospitals revealed only marginal or no differences between groups over time,

with the exception of nurses' perception of clinical quality (Salmon et al., 2003). Results

from the Center for Substance Abuse Treatment (2004) study on opioid treatment

programs showed that accreditation increased staff retention and led to more

comprehensive services, but data from statistical tests were not consistently reported.

Six studies had pre-test and post-test data but did not have a comparison group

(DiRusso et al., 2001; Frasco et al., 2005; Kassebaum et al., 1997; Mazmanian et al.,

1993; Sampalis et al., 1995; Volkwein et al., 2007), while 10 other studies (Adams, 2005;

Beaulieu & Epstein, 2002; Chen et al., 2003; Duckett, 1983; Duckett & Coombs, 1981;

Hadley & McGurrin, 1998; Hazard et al., 2002; Heras et al., 2002; Simons et al., 2002;

Whitebook et al., 1997) had group comparisons but did not have pre- and post-test data.

These studies showed mixed results. Some found that accreditation appeared to have a

positive impact, while others found no or inconsistent impact of accreditation on quality.

Three others were retrospective inquiries regarding employee perception of the impact of

accreditation (El-Jardali et al., 2008; Pomey et al., 2004; Zellman et al., 1994) that

revealed positive associations with accreditation on some indicators of quality. Other

studies (Abuhamad et al., 2004; Demestriades et al., 2005; Freud & Lichtenberg, 2000;

Miller et al., 2005; Moffett& Bohara, 2005; Pasquale et al., 2001; Stratton et al., 2004;

Volkwein et al., 2007) compared accreditation scores or levels of accreditation to

outcomes and found that accreditation was not always associated with better outcomes.

Overall, the studies showed only moderate evidence in support of accreditation. The results of the studies could be summarized in terms of the impact of accreditation on structural, process, and outcome indicators of quality. Eight of the 28 studies examined the effects of accreditation on structural indicators of quality, such as organizational capacity. Overall, they revealed both positive and neutral results regarding structure due to accreditation. The majority of the studies (22 of 28) examined the impact of accreditation on process indicators of quality, including monitoring procedures, course and content of services. Although several found that accreditation had a positive impact on process, the results were not always consistent. Nineteen of the 28 studies examined outcomes, including program outcomes, client outcomes, and client satisfaction. They found a mix of positive, negative, and neutral affects of accreditation.

Key Findings from Studies on COA and/or Children's Mental Health Care

Only two studies focused on COA and/or accreditation of children's mental health care. Stratton et al.'s (2004) unpublished study on children's residential treatment compared differences in treatment processes and outcomes at eight COA-accredited facilities, 17 JCAHO-accredited facilities, and 13 non-accredited facilities in Kentucky. Data collected annually for three years revealed inconsistent results regarding accreditation's effect on procedures connected to technical care and sensitivity of care. No baseline data prior to accreditation were examined. Although non-accredited facilities were making more general treatment process mistakes at year one, all facilities improved by year three. There was an increase in total number of mistakes at non-accredited facilities at year two and then a decrease in year three. For cultural competence processes,

36

JCAHO-accredited and non-accredited facilities had more mistakes at year one than COA-accredited facilities. All facilities improved at year two, but JCAHO-accredited facilities increased new mistakes and total number of mistakes at year three. Stratton et al.'s (2004) study also found that, by year three, program discharge outcomes, Child Behavioral Checklist (CBCL) outcomes, and client discharge outcomes were all statistically the same for COA-accredited, JCAHO-accredited, and non-accredited facilities. The authors assert that the state's reviews of all children's residential treatment programs could have contributed to similarities between accredited and non-accredited programs in their study.

Hazard et al.'s (2002) unpublished study on COA accreditation of foster care organizations employed a matched subjects design with three COA-accredited foster care organizations and three non-accredited foster care organizations. Qualitative data were gathered from questionnaires, interviews, and review of organizations' documents. Hazard and colleagues found that only the COA accredited foster care organizations had implemented risk management, performance evaluation, and corrective action processes. Although accreditation was associated with the implementation of some processes, there was no clear pattern of difference between accredited and non-accredited organizations in other processes, such as internal quality monitoring, stakeholder participation, case record review, outcomes measurement, feedback mechanisms, personnel satisfaction or service specific processes. There was also no clear pattern of difference regarding consumer satisfaction between accredited and non-accredited organizations.

Methodological Issues from the Empirical Research

A review of the current evidence on the impact of accreditation revealed some methodological issues, such as lack of strong research designs, selection bias, measuring quality, and the lack of theory.

There is a need for stronger research designs in order to build the evidence base on accreditation. Only two studies on accreditation were randomized control trials and six other studies had pre- and post-test data but no comparison group, and 10 other studies had group comparisons with no pre- and post-test data. More evidence on the impact of accreditation on client and organizational level outcomes is needed. Randomized control trials and ex post facto quasi-experimental studies could compare pre-accreditation and post-accreditation data from accredited and non accredited organizations. Studies could examine various accreditors and one type of service or various services by one accreditor.

Selection bias is a methodological challenge for researching accreditation. Organizations that have little chance of meeting accreditation standards may simply chose not to apply for accreditation (Mays, 2004); organizations that already have superior performance may be applying for accreditation (Heras et al., 2002). As a result, "the pool of organizations that seek accreditation can become skewed toward organizations most likely to meet accreditation standards" (Mays, 2004, p. 15). This could make it difficult to distinguish selection effects from the actual effects of accreditation (Mays, 2004). One factor that may diminish the effects of selection bias is when certain legislation and policies make accreditation mandatory, thus requiring all organizations to apply for accreditation no matter their chance of achieving accreditation. For example, the Department of Human Services requires community mental health

contractors receiving over $20,000/year from the department to be accredited (COA, 2007c).

In addition to organizational selection bias, there may also be selection bias on the client level. Consumers who are less likely to get better may be served at accredited agencies in the hopes of receiving high quality care, thus contributing to case mix issues that may make it difficult to show differences when examining consumer outcomes between accredited and non accredited organizations. Risk-adjustment tools could control for such client characteristics and propensity score matching techniques could control for selection biases.

Measuring quality is also another methodological challenge when examining the impact of accreditation. Studies measured various structure, process, and/or outcomes as indicators of quality. Structure and process may not always lead to outcomes, thus outcomes may not always be the most valid indicator of quality (McMillen et al., 2005). For example, some clients may have better outcomes despite poor care and some may have worse outcomes although receiving best care, thus process measures, such as variations in who receives services, how much and how long, extent of guideline-concordant care, and interactions between consumers and providers, may have advantages over outcome measures (McMillen et al., 2005). Brook, McGlynn, and Cleary (1996) assert that some argue that emphasizing processes may not produce improved outcomes, but "process data are usually more sensitive measures of quality than outcome data, because a poor outcome does not occur every time that there is an error in the provision of care" (p. 966).

While accreditation seems to be promising for improving some quality indicators, the challenge of measuring quality has also led to mixed and inconsistent results regarding the impact of accreditation. Despite the increasing use of accreditation in various fields, the evidence base concerning the effectiveness and impact of accreditation remains relatively limited (Cerqueira, n.d.; Mays, 2004). More is needed.

<div align="center">Summary of Empirical Findings and Gaps in Knowledge</div>

Accreditation is a world-wide phenomenon but there is no published empirical research regarding the impact of accreditation on the quality of mental health care. This review revealed that there are only two unpublished studies on COA accreditation and/or accreditation of mental health services. The majority of the empirical research is on hospital accreditation.

Building towards a theory of accreditation can lead to more empirical research to inform the practices and policies regarding accreditation. It is not known how accreditation is meant to work to effectively improve quality of care. There is also little understanding of why agencies choose to seek or do not seek accreditation (Nichols & Schilit, 1992). The impact of accreditation needs to be rigorously evaluated in order to understand if and how accreditation makes a difference for mental health agencies and their consumers. Closer examination of the accreditation process will reveal what "active ingredients" of accreditation make a difference.

CHAPTER THREE: THEORETICAL PERSPECTIVES AND CONCEPTUAL
FRAMEWORK OF ACCREDITATION

To begin building a theory of how accreditation is supposed to work, this chapter

examines theoretical perspectives from other areas that informed this study's aims and

conceptual framework. Theory of regulation and organizational theory inform the first

aim which explores children's mental health agencies' motivations for pursuing

accreditation. Why would agencies be motivated to seek accreditation? Why would the

government encourage accreditation? Organizational social context theory sheds light on

the second aim regarding agency's experience with accreditation. Under what

circumstances is the accreditation process most effective at creating or ensuring quality?

Donabedian's conceptualization of quality informs the third aim which focuses on how

the pursuit of accreditation may improve service delivery and outcomes. What are the

leverage points and mechanisms for how the accreditation process may improve quality?

Together, the three aims build upon each other to compose the conceptual framework that

guided this study to build toward a theory of accreditation.

Conceptual Framework of Accreditation

Currently, no theoretical models of accreditation exist. This conceptual

framework (Figure 3.1) was developed to guide the exploratory research questions for

this study and it could generate hypotheses for future studies. The conceptual framework

is comprised of this study's three aims. The first aim focuses on how policies that

recognize accreditation affect agencies' decision to pursue accreditation. The second aim

concentrates on how the organizational social context of agencies influences their

accreditation experience. The first and second aims are both a part of the third aim which examines quality indicators to understand how the accreditation process can help improve services. The structure, process, and outcome indicators can be affected directly by accreditation requirements or indirectly from by-products of accreditation. This conceptual framework can help to uncover why agencies pursue accreditation and if specific accreditation components and standards may be leading to service improvements by affecting indicators of quality.

Figure 3.1 Conceptual Framework of Accreditation
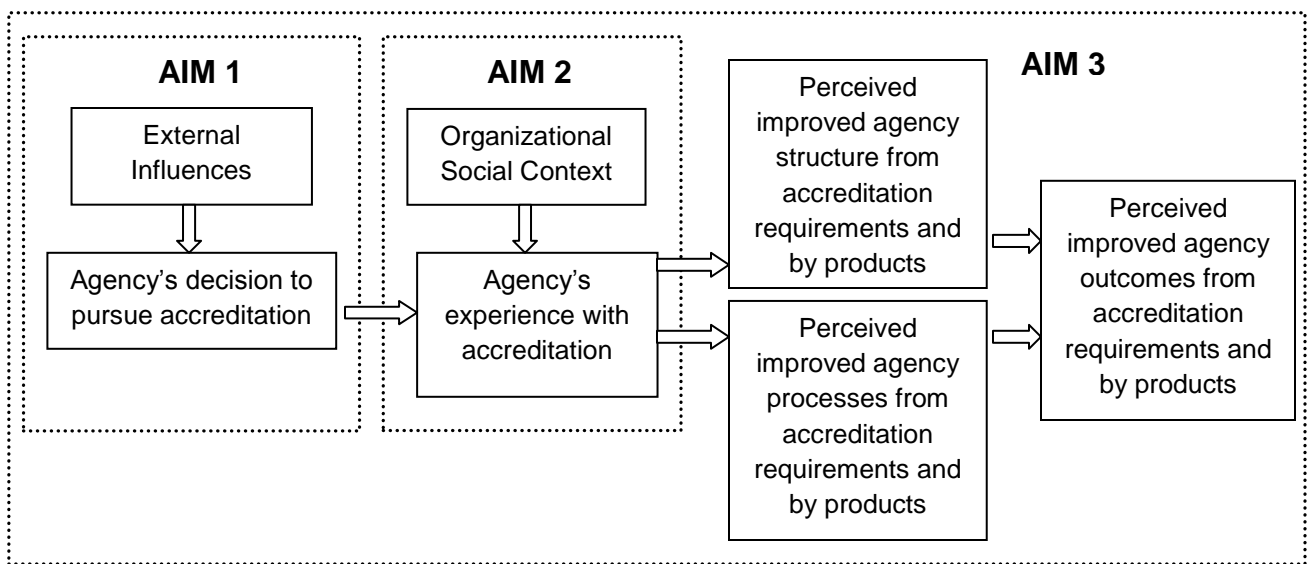
Aim 1: Theory of Regulation and Organizational Theory

Theory of regulation and organizational theory both can help explain factors that may influence whether an agency seeks accreditation and why policies recognize or support accreditation. Regulatory bodies, such as accreditors and government licensing departments, are part of an agency's external organizational environment. Due to a

powerful convergence of factors and incentives, both the government and agencies have reason to promote accreditation

Regulation is a set of influences or rules provided by an authority (Brennan & Berwick, 1996). The assumption behind the theory of regulation is that the government acts out of interest for the public (Baldwin & Cave, 1999; Breyer, 1982). In some regulation strategies, the government has direct control over agencies by creating consequences for not complying with regulatory standards, such as licensure (Ayres & Braithwaite, 1992). For example, only licensed entities can do business with the state, or in some cases, remain in business. Other regulation strategies are broader, such as enforced self-regulation and self-regulation. In enforced self-regulation there is negotiation between the government and the industry in establishing regulations (Ayres & Braithwaite, 1992). In self-regulation, government has no direct role and the industry is left to regulate itself with self-imposed rules (Ayres & Braithwaite, 1992). Accreditation fills the gap between the latter two regulation strategies. The government can give oversight responsibilities to the accreditor, possibly acting out of self-interest to avoid any risk incurred, or the industry can argue that it can police itself through accreditation. Accreditation is a tool for regulation, and this highlights reasons why government and industry both push agencies toward accreditation.

Accreditation's influence lies mainly in between enforced self-regulation and self-regulation because it is attractive to both agencies and the government. Since the government does not entirely trust agencies to self-regulate, accreditation plays the role of the third party guarantor. Accreditation is attractive to agencies because it can fend off government interference; achieving accreditation signals to the government that the

agency has already met the highest standards in the industry. When the government

agrees that accreditation is enough to assure that the agency is providing high quality

services, it recognizes accreditation in various policies. These policies could include

higher reimbursement rates for accredited agencies, deemed status to allow agencies to

substitute accreditation for government requirements for licensure or inspections, or

mandated accreditation (COA, 2007c). These types of recognition policies provide

further incentives for agencies to pursue accreditation, but there may be no incentives for

agencies to continuously improve quality in between accreditation cycles if the goal is to

avoid government interference.

According to Ayres and Braithwaite (1992), when self-regulation works well, it is

least burdensome to the industry and tax payers (Ayres & Braithwaite, 1992). When the

government negotiates the goals of regulation with the industry, it leads to the best

chance of meeting the goals of both parties efficiently (Ayres & Braithwaite, 1992).

Thus, the government may choose self-regulation strategies, if it trusts the third party,

because it is more efficient, cheaper, and allows more in-depth inspections (Ayres &

Braithwaite, 1992). In addition, government may lack the ability and in-depth expertise in

various fields to regulate. This also helps motivate governments to encourage

accreditation.

Regulation and policies that recognize accreditation are part of an agency's

organizational environment. According to organizational theory, the organizational

environment consists of external constraints and demands that organizations have to

adapt to in order to survive (Hatch, 2006). An organization may pursue accreditation as a

response to demands in the organizational environment. For example, an agency may

pursue accreditation to receive increases in reimbursement rates, gain regulatory relief from deemed status, or because accreditation is mandated. In addition to policies that recognize accreditation, an agency may feel pressured to seek accreditation if other agencies are becoming accredited in order to remain competitive for referrals. According to Porter (1980), organizations may seek to differentiate themselves from competitors as part of their competitive strategy; accreditation may be one way to signal distinction.

If an agency decides to pursue accreditation to gain these advantages rather than using accreditation to provide better services, accreditation may be less likely to improve quality of care. For example, some agencies seeking accreditation solely for the incentives may focus only on passing the standards for the accreditors at the time of review and not maintain implementation of the standards afterwards. Also, regulation strategies, such as accreditation, could hinder quality efforts if the strategies emphasize policing instead of continuous improvement (Brennan, 1998). In addition, Brennan and Berwick (1996) assert that the multiple demands of heterogeneous regulation from various entities such as licensure and/or accreditation could result in excessive financial costs as well as time and resources that could, ironically, decrease quality of care. This can be attributed to competition and regulation in the organizational environment.

Aim 2: Organizational Social Context Theory

In addition to the larger organizational environment outside of the agency, the organizational social context *within* the agency may influence how the agency experiences accreditation. According to Glisson (2002), the organizational social context includes the organizational culture (rigidity, proficiency, resistance), and climate (stress,

45

Figure 3.2 Conceptual Model of Organizational Social Context from Glisson (2002)

Organizational	Properties	Individual and
Shared Perceptions Work	Performance	

```
┌──────────────┐          ┌──────────────┐          ┌──────────────┐
│   Culture    │          │ Psychological│          │ Work Attitudes│
│              │          │   Climate    │          │              │
└──────────────┘          └──────────────┘          └──────────────┘
      ↕                          ↕                         ↕
┌──────────────┐          ┌──────────────┐
│  Structure   │          │ Work Behavior│
└──────────────┘          └──────────────┘
```
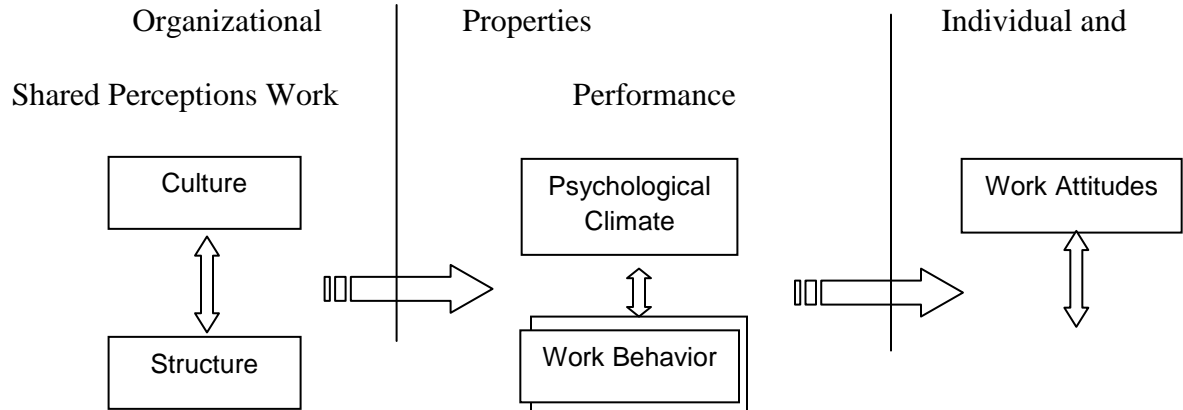
engagement, functionality) that affects employees' work attitudes (morale) (Figure 3.2).

Organizational culture is the shared behavioral expectations in an organization as related

to the organizational structure, which is the formalization of roles and centralization or

decentralization of power (Glisson, 2002). Culture and structure, in turn, affect the

organizational climate, which is the workers' shared perception of the psychological

impact of the work environment on his or her well-being (Glisson, 2002). Climate then

influences employee's job satisfaction and organizational commitment (Glisson, 2002).

Organizational culture and climate have been linked to quality and outcomes of

children's services (Glisson, Dukes, & Green, 2006; Glisson & Green, 2006; Glisson &

Hemmelgarn, 1998; Glisson & James, 2002). For example, Glisson and Green (2006)

found that children served by child welfare and juvenile justice case management units

with constructive organizational cultures were more likely to receive the needed mental

health care. Glisson and Hemmelgarn (2002) found that positive organizational climate

was a predictor of positive outcomes, such as children's improved psychosocial

functioning.

Glisson's theory postulates that children's mental health services will differ depending on the organizational social context, which, in turn, may affect the likelihood of changing behaviors and employee work performance, thus affecting variations in quality and client outcomes (Glisson, 2002; Glisson, Landsverk, et al., 2008). The organizational social context of children mental health agencies can invite or reject innovation, promote or hinder the activities needed for responsive services, and sustain or adapt treatment protocols and technologies that are required for effective services (Glisson, 2002). This has also been supported by other literature such as the work of Shortell and colleagues (1995; 2004) which found that organizational culture was associated with employees' willingness to take on quality improvement efforts as well as the changes made during those efforts. A recent study by Glisson and colleagues (Glisson, Schoenwald, et al., 2008) found that organizations with the best climates had annual turnover rates that were less than half the rates found in organizations with the worst climates. Organizations with the best culture sustained new treatments or service programs more than twice as long as organizations with the worst cultures.

The accreditation process can be viewed as a potential quality improvement intervention, thus the organizational social context could affect how agencies experience accreditation and how they adopt accreditation as an intervention to improve quality of services. For example, at agencies that are characterized as having high levels of stress and work overload, employees may find accreditation to be particularly burdensome and report a negative accreditation experience. Accreditation could overload and overwhelm employees, hindering them from using accreditation as a tool for quality improvement. In contrast, agencies that have high proficiency and morale may have a positive

47

accreditation experience and perhaps view it as an opportunity to prove the quality of their services. Employees may be excited to work toward achieving successful accreditation and see it as way to improve services. Organizational social context theory may help reveal how agencies react to accreditation and under what circumstances accreditation is most effective at improving quality of care.

Aim 3: Donabedian's Theoretical Conceptualization of Quality

Donabedian's theoretical conceptualization of quality helps explain how accreditation may improve quality. Donabedian conceptualized quality as a function of structure, process, and outcomes (Donabedian, 1988). Structural factors describe the environment of service or staff characteristics, while process variables describe the content or course of service, and outcomes examine the results of service (Nabors, Weist, Holden, & Tashman, 1999; Abe-Kim & Takeuchi, 1996). According to Donabedian (1988), "Good structure increases the likelihood of good process, and good process increases the likelihood of a good outcome" (p. 1745). Although other models provide more detail, Donabeidan's foundational theory will be used for this conceptual model since it is exploratory and will allow for further investigation and specificity for this theory-building.

Accreditation Requirements and Quality Indicators

Accreditation may affect quality indicators directly by setting accreditation requirements. The potent force of requiring agencies to have certain structures and processes in place may improve outcomes.

Structure. Some COA standards specify structural requirements that could influence outcomes. The purpose of COA's Administrative and Service Environment standards state that, "The organization's administrative and service environments are respectful, caring, safe, and accessible, and contribute to organizational productivity and effective service delivery" (COA, 2008a). Together, these standards address health and safety, facility maintenance, tools and equipment, all of which are part of the agency's structure or environment of care.

Embedded in COA's standards is the "principle that increased organizational capacity is linked to improved service and that this, in turn, results in better outcomes" (COA The 8th Edition Standards, n.d.). Regarding structural indicators of quality, staffing issues related to professional credentials are addressed, for example, in COA's residential treatment standards. The standards state that residential counselors, youth workers, adult care, and child care workers have a bachelor's degree and/or are actively, continuously obtaining the degree; supervisors of direct service personnel are licensed social workers with advanced degrees from an accredited program of social work with a specialty in clinical practice and have supervised post-graduate clinical experience consistent with state legal requirements for clinical practice; and a licensed psychiatrist assumes responsibility for the psychiatric elements of the program (COA, 2008h).

Process. Many of the leverage points for how COA accreditation can affect quality have to do with processes. Some accreditation standards establish timeframes for certain processes to be in place. For example, COA's services standards for residential treatment has timeframe requirements that could directly affect reliability and responsiveness of services. One of the standards requires that "An assessment based

49

service plan is developed within one week of admission, and comprehensive plan is developed within 30 days" (COA, 2008f). Another standard requires "Ongoing service goal monitoring, including at least quarterly treatment team review, ensures treatment at the appropriate level and assesses service plan implementation and progress toward achieving service goals and desired outcomes, including the need for continued treatment or changes in service goals" (COA, 2008i).

Accreditation may also help organizations create more efficient processes that could strengthen reliability and responsiveness of services (COA Value of contextual accreditation, n.d.). For example, COA has standards for performance and quality improvement (PQI) and states, "An organization-wide PQI program advances efficient, effective service delivery and achievement of strategic and program goals" (COA, 2006e). One of the PQI standards requires the organizations to have "…the infrastructure that supports performance and quality improvement is sufficient to identify organization-wide issues, implement solutions that improve overall productivity, and promote accessible, effective services in all regions and sites" (COA, 2008d).

Other standards could affect the course and content of care through requiring staff trainings. For example, one of COA's training and supervision standards requires:

> Training for direct service personnel addresses differences within the organization's service population, including:
> a. interventions that address cultural and socioeconomic factors in service delivery;
> b. the role cultural identity plays in motivating human behavior; and
> c. understanding bias or discrimination (COA, 2008k).

Some other training standards address legal issues, security of records, advocacy, crisis situation, health and medical needs of clients, public assistance and government subsidies (COA, 2008k).

In addition, COA has standards on ethics, client rights, and responsibilities which emphasize client involvement in the process of care. COA's standards on clients rights states:

> Clients participate in all service decisions and have the right to:
> a. request an in-house review of their care, treatment, and service plan;
> b. refuse any service, treatment, or medication, unless mandated by law or court order;
> c. be informed about the consequences of such refusal, which can include discharge.

Many other standards highlight client involvement, which can improve the course and content of care. Together, these standards may improve quality by requiring processes, such as trainings, and the monitoring of performance improvement efforts, and by underscoring client involvement.

Outcomes. COA's standards only vaguely address outcomes. According to COA, the "purpose standard states achievable outcomes for the area of practice and expresses the overall aim of the practices included in a section" (COA, 2008c). For example, the purpose standard for residential treatment is:

> Residential Treatment Services are delivered according to an articulated philosophy that ties individual needs to specific interventions and education, and to achievement of stated goals, such as gains in measurable skills, increased productivity and pro-social behavior, improved functioning, and a stable living arrangement in the community (COA, 2008g).

Thus, requirements for consumer and system-level outcomes are addressed but are somewhat vague in these purpose standards. Outcomes are also addressed in other parts of the self-study process. Each of COA's service standards requires certain documents to be included in the self-study, including two quarterly reports from the case record review process along with any related corrective action plans and two quarterly reports of

51

accidents, incidents, and grievances. This documentation requires that, in order to become accredited, the organization must monitor and demonstrate social service system-level outcomes and consumer outcomes such as sustained functioning and reduction in presenting problems. If an agency is not otherwise doing so, the initiation of outcomes monitored could prove enlightening and lead to specific improvement efforts.

By-Products of Accreditation and Quality Indicators

In addition to the direct requirements set by accreditation, accreditation can also improve quality and outcomes indirectly through its by-products. Indirect results from COA accreditation could affect an agency's service delivery.

Structure. These by-products could affect structural indicators such as increased funding from recognition of accreditation. The recognition of accreditation by governmental entities could increase funding opportunities, which in turn could increase available resources and increase access to care. Accreditation could also lead to more client referrals which could increase revenue and improve tangibles for the organization.

Process. The by-products could also affect process indicators of quality. For example, accreditation may indirectly affect reliability and responsiveness by reducing hidden costs such as employee turnover (COA Value of contextual accreditation, n.d.). According to a GAO report, accreditation was one of the practices that helped prevent public child welfare caseworker vacancies (US GAO, 2003). COA accreditation may increase staff satisfaction and retention. In a study on accreditation of child development centers, Zellman and colleagues (1994) found that higher staff morale and pride from increased prestige and recognition was the most frequently reported benefit of

52

accreditation by center directors. These by-products of accreditation could also possibly lead to reliability and responsiveness of services, better staff performance and improved services.

Outcomes. Although accreditation does not guarantee improved outcomes (Brommel, 2006), improved outcomes may be the ultimate by-product of accreditation. COA's philosophy is that, "Accreditation is not an end but a means to an end. The real endpoint of COA accreditation is an organization's enhanced growth and stability, an unwavering commitment to the health, safety, and rights of clients, and measurable results" (COA, 2008e). Continuous quality improvement which can lead to measurable improvement in outcomes can be the result of the COA accreditation process.

Summary

This chapter assembled various theories related to accreditation—the motivations behind accreditation, agencies' experiences with accreditation, and how the pursuit of accreditation may improve services. Together these theories presented an initial conceptual framework but much remains to be discovered. This study used this conceptual framework to delve further into understanding the theoretical underpinnings to explain how the pursuit of accreditation can improve quality of care.

CHAPTER FOUR: RESEARCH DESIGN AND METHODOLOGY

This study employed a mixed methods multiple case study design in which several cases were studied to investigate the research questions (Stake, 1995; Stake, 2006). Compared to an instrumental case study in which one case is the focus (Stake, 1995), a multiple case study was selected in order to capture variation in settings and contexts in which accreditation occurs (Stake, 2006). Each case has its own unique story to tell and the similarities, as well as contradictions among the cases, will help us understand accreditation as a whole (Stake, 2006).

While purely qualitative methods focus on *individual* accounts of the accreditation experience, a mixed methods multiple case study design revealed each *agency's* account. Thus, the unit of analysis for this study was the children's mental health agency. The nature of case study research is "the study of the particularity and complexity of a case" (Stake, 1995, p. xi). The purpose was not to generalize findings but to capture the mechanisms behind accreditation at the selected agencies.

With multiple case study methodology as the overarching framework, this research design used a concurrent strategy with triangulation for the mixed methods (Figure 4.1) (Creswell, 2003; J. Creswell, personal communication, June 26, 2009; Stake, 1995). Qualitative and quantitative data were collected simultaneously and compared to one another. To explore the phenomenon of accreditation "within its real-life context" (Yin, 1984, p. 23), multiple sources of evidence included 1) in-depth interviews with key informant employees and other informants who agree to participate in focus groups, 2) survey data from all employees, 3) review of documents pertinent to the accreditation process, and 4) limited observations at the agencies.

54

Figure 4.1 Research Design Overview: Concurrent Multiple Case Study with Triangulation

```
┌─────────────────────────────────────────────────────────────────────────┐
│                      MULTIPLE CASE STUDY FRAMEWORK                        │
│  ┌·····················································································┐  │
│  ┊         Data Collection and Analysis at each of the Five Agencies      ┊  │
│  ┊                                                                         ┊  │
│  ┊  ┌──────────────┐    ┌──────────────┐    ┌──────────────┐    ┌──────────────┐ ┊  │
│  ┊  │ INTERVIEW/   │ +  │   Survey     │ +  │  Document    │ +  │  Limited     │ ┊  │
│  ┊  │ FOCUS GROUP  │    │ Data & Results│    │  Review      │    │ Observations │ ┊  │
│  ┊  │ DATA &       │    │              │    │ Data & Results│    │ Data & Results│ ┊  │
│  ┊  │ RESULTS      │    │              │    │              │    │              │ ┊  │
│  ┊  └──────────────┘    └──────────────┘    └──────────────┘    └──────────────┘ ┊  │
│  ┊         ⇓                  ⇓                  ⇓                  ⇓          ┊  │
│  ┊  ┌───────────────────────────────────────────────────────────────────┐  ┊  │
│  ┊  │                        Interpretation                             │  ┊  │
│  ┊  └───────────────────────────────────────────────────────────────────┘  ┊  │
│  └·····················································································┘  │
│                                   ⇓                                        │
│                  Cross Case Analysis of the Five Agencies                  │
└─────────────────────────────────────────────────────────────────────────┘
```
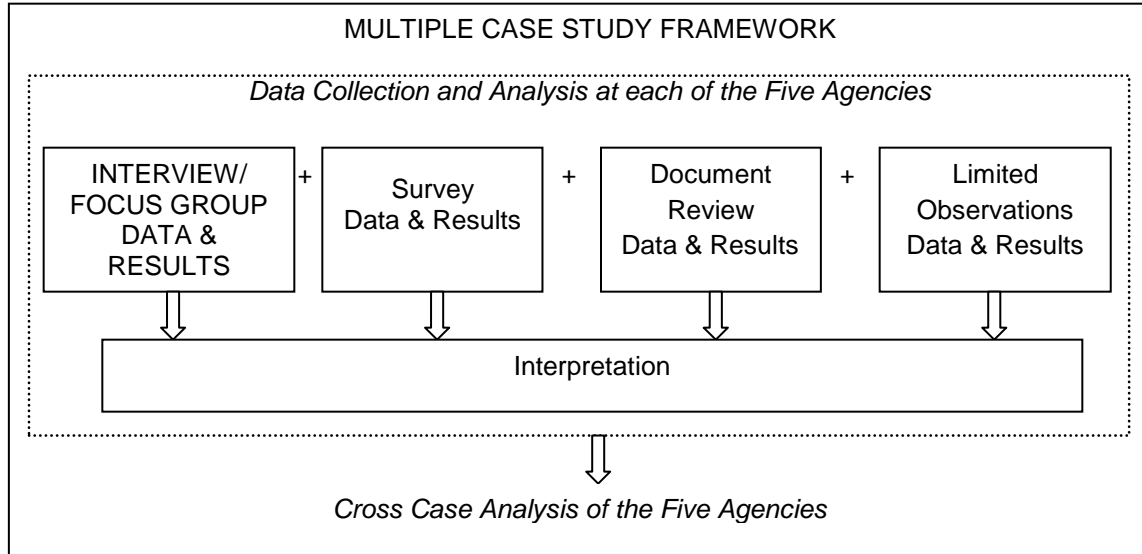
Qualitative data from interviews and focus groups were prioritized to provide rich descriptions of accreditation experiences. Secondarily, quantitative survey data characterized each agency in terms of their organizational social context and provided a broader view on accreditation from all employees. A review of documents and limited observations supplemented and triangulated these data. Data from each of the five agencies were also compared for cross-case analysis. Prior to the start of the study, approval was obtained from the Washington University Human Research Protection Office and modifications were approved as necessary.

Agency Inclusion Criteria and Sampling Strategy

Three inclusion criteria together with a sampling strategy were used to target agencies for this study. The first criterion included children's mental health agencies that provide one or more of the following services and responded to those service standards as

55

defined by COA: outpatient mental health services, day treatment, residential treatment, therapeutic foster care, group living services, counseling, support, and education services, family preservation and stabilization services, emergency shelter services, crisis response, wilderness adventure-based therapeutic outdoor services, social development, or child and family development services.

The second criterion included children's mental health agencies that have completed their initial COA accreditation (not reaccreditation) and are awaiting an accreditation decision or have been accredited by COA for less than 12 months. Agencies awaiting an accreditation decision were targeted first before targeting agencies that were already accredited since timing could be crucial for keeping data as unbiased as possible. For instance, if data were collected after an agency receives an accreditation decision, the decision could color their views on their experience; a successful accreditation may garner more positive responses while an unsuccessful accreditation could bias the responses regarding the accreditation process to be more negative. Alternatively, agencies that have been accredited would be able to share about the impact of being COA accredited, in addition to the impact of the accreditation process.

The third criterion included agencies that have not been and are not currently accredited by another national accrediting body, such as the Joint Commission or CARF. Agencies that were accredited by a state level association still met the inclusion criterion.

In addition to the three criteria, the sampling strategy targeted children's mental health agencies located in different states, since the study aimed to compare accreditation in different state policy contexts. This variation in location helped to explore how different state policies may affect agencies' motivation to pursue accreditation. These
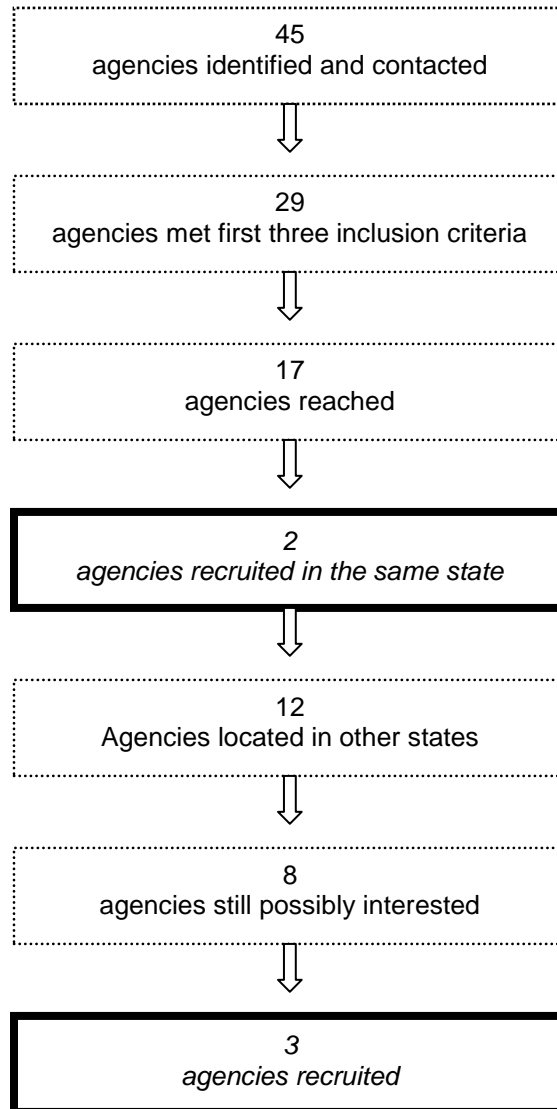
policies could provide various incentives for accreditation, including higher

reimbursement rates for accredited agencies, deemed status to allow agencies to

substitute accreditation for government requirements for licensure or inspections, or

mandated accreditation (COA, 2007c). Although case selection was not stratified by state

as in quantitative studies, this approach aimed to capture diversity across contexts (Stake,

2006).

<center>Identification and Recruitment of Agencies</center>

This study selected five children's mental health agencies. According to Stake,

"Two or three cases do not show enough of the interactivity between cases, whereas 15 to

30 cases provide more uniqueness of interactivity than the researcher and readers can

understand" (Stake, 2006, p. 22). In addition, the criteria for selecting cases "does not

depend on being able to defend the typicality of the case" but rather the cases should have

"balance and variety" (Stake, 1995, pp. 4-6). Thus five agencies were selected for the

scope of this exploratory study (Figure 4.2).

Several strategies of outreach and networking were employed to identify agencies

that met the inclusion criteria. Personal contacts at COA and at other children's mental

health associations and agencies were utilized first. Another strategy was to attend a COA

training to approach representatives from agencies that were getting ready or have started

the accreditation process and also ask if they knew of other agencies that may be

undergoing COA accreditation. Lists and directories of child serving agencies were

gathered from state licensing authorities and by searching online. These strategies yielded

<center>57</center>

Figure 4.2 Case Recruitment

```
┌─────────────────────────────────────────┐
┊                    45                    ┊
┊      agencies identified and contacted   ┊
└─────────────────────────────────────────┘
                     ⇩
┌─────────────────────────────────────────┐
┊                    29                    ┊
┊   agencies met first three inclusion criteria ┊
└─────────────────────────────────────────┘
                     ⇩
┌─────────────────────────────────────────┐
┊                    17                    ┊
┊             agencies reached             ┊
└─────────────────────────────────────────┘
                     ⇩
┏━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━┓
┃                     2                    ┃
┃      agencies recruited in the same state ┃
┗━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━┛
                     ⇩
┌─────────────────────────────────────────┐
┊                    12                    ┊
┊        Agencies located in other states  ┊
└─────────────────────────────────────────┘
                     ⇩
┌─────────────────────────────────────────┐
┊                     8                    ┊
┊      agencies still possibly interested  ┊
└─────────────────────────────────────────┘
                     ⇩
┏━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━┓
┃                     3                    ┃
┃             agencies recruited           ┃
┗━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━━┛
```

a list of 45 agencies located all over the country that had the potential to meet the

inclusion criteria.

Attempts were made to contact all 45 agencies and to speak with the point person

for the accreditation efforts. Sixteen of the 45 identified agencies did not meet the

inclusion criteria; four were too early in their accreditation process to be included in the

study, three other agencies had been accredited by COA for more than 12 months, one

was pursuing CARF accreditation, another was in the process of switching from CARF to COA, five had stopped the COA accreditation process, and two other agencies did not provide any of the mental health services in the inclusion criteria.

Twelve of the remaining 29 agencies could not be reached (wrong telephone number or did not return messages), leaving 17 agencies. Two agencies located in the same state agreed to participate in the study. Since the study aimed to compare accreditation in different state policy contexts that provide various incentives for accreditation, three other agencies that were located in the state where these two agencies had already agreed to participate were not contacted. This left 12 agencies in the recruitment pool for the additional three cases. During the recruitment process, four of the 12 agencies decided not to participate in this study. Of the remaining 8 agencies, one that was far along in their accreditation process and two that had become COA accredited in the past 12 months also agreed to participate in this study. Together, these five agencies provided variety in policy contexts, mental health services provided, and agency size.

Recruitment of Participants

Once an agency was recruited, employee participants were then recruited by continuing to work with the point person for the agency's accreditation process, who became my liaison. The liaison and I discussed which employees were most involved in the accreditation process and would best serve as informants for the interviews and focus groups. An organizational chart was consulted when available. This was used in an effort

to recruit employees from all levels of the agency and to make certain that employees were not purposefully excluded due to their opinions about COA.

Key informants who were able to provide in-depth information about the accreditation experience were selected for an individual interview. According to Gilchrist and Williams (1999), key informants are people who can provide informed opinions about the research problem by virtue of their special status, knowledge, expertise, access, or communication skills. Other informants who were not able to provide in-depth information but participated in the accreditation process were considered for inclusion in a focus group. When composing the groups, Krueger and Casey (2000) suggest having enough variation in participant's opinions, yet not too much variation that some participants may feel inhibited to share. The groups were composed of relatively homogenous groups of employees that held the same position or were on the same organizational level, with no supervisors present (Morgan & Krueger, 1993). This helped to create a non-threatening environment for the employees to express their views freely (Morgan & Krueger, 1993).

In order to ensure that employees were not pressured to participate, a formal agreement was made with the agency's Executive Director that feedback about any employee's individual responses would not be shared with the agency and employees' participation, their responses, or lack of participation in any part of the study would in no way affect employees' performance evaluations or status in any way. This agreement was documented on an Assurance of Participation form signed by myself and the agency's Executive Director prior to planning data collection.

All employees were recruited to participate in the survey and were informed about the

limited observations prior to the data collection visit. To recruit survey participants, I

used a memo introducing the study and inviting all employees to participate in the survey

that was distributed by the liaison throughout the agency. When possible, flyers were

posted to advertise the reception hosted for the survey distribution and reminder emails

were sent to employees during and after the visit. For the limited observations, employees

did not need to be actively recruited, but the introductory memo distributed before the

visit also included a Research Information Sheet about the observations since the liaison

provided a tour of the agency

Data Collection

Data were collected across cases through in-depth interviews, focus groups,

surveys, document reviews, and limited observations. Table 4.1 provides an overview of

the measures, sources, and the theory-building constructs the data intend to inform. The

combination of these various sources of data provided a rich description of the

accreditation process at each agency.

Interview/Focus Group Data

Two methods were used to collect interview data—in-depth qualitative interviews and

focus groups. To gain in-depth information, qualitative interviews were used to

reconstruct perceptions of the accreditation experience with the key informants (DiCicco-

Bloom & Crabtree, 2006). Focus groups with other employees were conducted to

understand the range of perspectives about accreditation. In addition, the interactions

Table 4.1 Data Collection: Measures and Sources

Theory-building Constructs	Aim(s)	Method/ Measure	Measure Source	Data Source	Type of Data
Agency's decision to pursue accreditation	1	In-Depth Interview	Protocol developed for current study (question #1)	Key Informants	Qualitative
		Focus Groups	Protocol developed for current study (question #1)	Other Informants	Qualitative
Recognition of accreditation	1	In-Depth Interview	Protocol developed for current study (question #1)	Key Informants	Qualitative
		Focus Groups	Protocol developed for current study (question #1)	Other Informants	Qualitative
Agency's experience with accreditation	2	In-Depth Interview	Protocol developed for current study (questions #2-10)	Key Informants	Qualitative
		Focus Groups	Protocol developed for current study (questions #2-10)	Other Informants	Qualitative
		Survey	Developed for current study (questions #1-9)	All Employees	Quantitative
		Document Review	Agency (including self-study and pre-commission report)	Agency Documents	Qualitative/ Quantitative
Organizational Social Context	2	Organizational Social Context	Glisson, Landsverk, et al. (2008)	All Employees	Quantitative
		Limited Observations	Agency	Observations at Agency	Qualitative
Agency's perception of impact of accreditation on structure, process, outcomes	1, 2, 3	In-Depth Interview	Protocol developed for current study (questions #11-13)	Key Informants	Qualitative
		Focus Groups	Protocol developed for current study (questions #11-13)	Other Informants	Qualitative
		Survey	Developed for current study (questions #1, 2, 10, 11, 20) and adapted from El-Jardal et al., (2008) (questions #12-19)	All Employees	Quantitative
		Document Review	Agency (including self-study and pre-commission report)	Agency Documents	Qualitative/ Quantitative

among the employees during the focus group sessions revealed more dialogue about their opinions (Morgan & Krueger, 1993).

The questions for the interview (Appendix A) and focus groups (Appendix B) both concentrated on understanding why the agency pursued accreditation (motivations), their involvement in the process and the benefits and challenges they faced (experiences), and their opinions on how the accreditation process enhanced and hindered quality service delivery and how it could be better structured to be more beneficial (perceptions). Concurrent qualitative data collection and analysis allowed the interview and focus group questions to be more tailored as understanding of the research questions increased (DiCicco-Bloom & Crabtree, 2006).

At the start of each session, the permission to participate form was reviewed with the employees to emphasize voluntary participation, confidentiality, and anonymity. Employees were also informed that the Executive Director had assured that their participation or lack thereof or would not affect their employment in any way. Each interview and focus group lasted for about an hour. While notes were taken during each session, they were also digitally recorded after attaining each employee's permission so that they could be transcribed by a transcription service. All data and results were stored in a password-protected computer file. Digital recordings from each interview were transferred with a USB cable to a password protected computer and erased from the recorder.

Survey Data

A self-administered survey was used to collect quantitative data (Appendix C). Similar to the qualitative interview, the surveys asked employees about the benefits and

challenges they experienced during the accreditation process, as well as their level of involvement in the process. Since no standardized measures specifically address these issues, several survey questions regarding the employees' level of involvement and their accreditation experience were developed specifically for this study and other questions regarding the benefits of accreditation were adapted from El-Jardal et al.'s (2008) study on Lebanese nurses' perceptions of the impact of hospital accreditation on quality of care. The survey also included one open-ended question that asked participants about how they thought the agency has benefited from the accreditation process.

The survey also included Glisson's (2002; Glisson, Landsverk, et al., 2008) Organizational Social Context (OSC) measure purchased from the Children's Mental Health Services Research Center at the University of Tennessee Knoxville. This standardized measure uses 105 Likert scale items to assess multiple dimensions regarding the organizational social context of mental health organizations and has Cronbach alphas that indicate high reliability (ranging from 0.78 to 0.94) for all of its subscales (rigidity, proficiency, resistance, stress, engagement, functionality, morale).

Different strategies were required for survey distribution. Depending on the needs of each agency, the surveys were distributed at a reception during the data collection visit, following the interviews and focus groups, if time permitted, or in employees' mailboxes and returned to the liaison or directly to me in stamped and labeled envelopes. The surveys took approximately 20 minutes to complete. Since a waiver of consent was approved, Research Information Sheets describing the study were distributed with the surveys.

Document Review

The case study included a review of documents related to the history of the agency and the accreditation process (Appendix D). The documents included the self-study that each agency submitted to COA as well as the Pre-Commission Report(s) (PCR) from COA. The self-study involved the submission of documentation, or what COA calls 'evidence', in response to the accreditation standards, including a quality improvement plan, annual reports, quarterly case reviews, and corrective action plans, which may include quantitative data. The PCR provided recommendations for the agency following review of the self-study and the site-visit. Meeting minutes and other correspondence regarding the accreditation process were also reviewed. These documents augmented and triangulated data when participants referred to them during the in-depth interviews and on the surveys. Copies of some key documents were obtained, if needed, but they did not include any client identifying information.

Limited Observations

The case study also included limited observations at each agency but did not include attendance in any meetings or activities that may involve the disclosure of confidential client information. Since a waiver of informed consent was approved for the limited observations, the liaison was asked to distribute the Research Information Sheets, along with a brief memo introducing the study before the data collection visit. Additional information sheets were kept on hand to distribute to employees if inquired during the visit.

A tour of the agency's facilities with the liaison provided an introduction to the agency layout, resources available, and context for service delivery. The physical space and environment were noted and observations were recorded (Appendix E). The observations also described what physical, structural changes have been made due to accreditation requirements. These observations portrayed the setting for accreditation and service delivery and described the various contexts of each case (Stake, 1995), what accreditation looks like in action, and a full description of the agency as part of the in-depth approach to each case.

Data Analysis

Various types of data analyses were employed to develop a rich contextual understanding of how accreditation works and how to make the accreditation process more beneficial. A grounded theory approach was used to analyze the qualitative data from in-depth interviews and focus groups. For the quantitative surveys, data analysis involves generating organizations' social context profiles, as well descriptive statistics regarding the employees' experiences and their level of involvement. Analysis of data from the document reviews and limited observations triangulated and supplement other data. To gain an aggregate understanding of the research questions, cross-case analysis was employed, thus further supporting hypotheses generation.

Interview/Focus Group Data

Interview and focus group transcripts were entered into and managed using the NVivo8 (Qualitative Solutions and Research, 2006) software program. These qualitative

data were analyzed using grounded theory since it emphasizes the discovery of hypotheses from texts and building explanatory models (Bernard, 2006). Engaging in an iterative process of inductive coding led to analytic categories 'grounded' in the data (Charmaz, 2006; Strauss & Corbin, 1990).

After collecting data for the first case, emerging categories and themes were considered and discussed with my dissertation advisor and a first-iteration codebook was developed. As the project unfolded, case by case, I took copious notes, analyzed transcribed interviews, wrote case notes, discussed the case with my advisor and wrote the mini-case study. This process, of course, yielded new issues, new themes, and helped refine definitions of previous codes, necessitating multiple codebook revisions. This, in turn, required some recoding of prior research materials. This is inherent in collecting and analyzing data simultaneously in grounded theory (Charmaz, 2006). The data were sorted and compared to examine how the categories related to each other and to identify overarching themes (Bernard, 2006). Exemplar quotes from employees were used to support an explanatory model of accreditation (Bernard, 2006).

Survey Data

Quantitative survey data augmented the interview data since similar questions were asked for both types of data. The qualitative method was predominant in this study, and the surveys captured a broader picture of accreditation at the agencies since they were distributed to all employees.

Data from the survey questions developed for this study were entered in to Microsoft Access and then imported into SAS 9.1 for analyses. These quantitative data

67

were descriptive, adding each agency's accreditation story. For each case, these data were compared to the qualitative data to look for congruence between what was revealed in the surveys, interviews and focus groups.

The completed Organizational Social Context measures were sent to the Children's Mental Health Services Research Center (CMHSRC) at the University of Tennessee, Knoxville and analyzed in consultation with their research team. Each agency's OSC data were compared to a profile of mental health organizations assessed in a nationwide study of 1,154 clinicians in 100 mental health clinics (Glisson, Landsverk, et al., 2008). This characterized each agency in this study in terms of how stressful their work environment is and how high or low the expectations regarding proficiency are compared to other organizations.

Document Review

Documents were used to "corroborate and augment evidence from other sources" (Yin, 1984, p. 80). In order to have unbiased critical analyses of the documents, it was kept in mind that the documents were generated for a specific purpose and audience other than for this study (Yin, 1984). The self-studies submitted to COA by the agencies included continuous quality improvement (CQI) plans, quarterly reports on incidents, accidents, and grievances that were analyzed to corroborate and augment evidence from other sources. In addition, the number and nature of recommendations on Pre-Commission Report (PCR) were analyzed and compared between cases. The goal was to supplement other data with the documents and summarize key characteristics of each case.

Limited Observations

The observations provided additional information about the context of accreditation. For example, "the condition of buildings or work spaces will indicate something about the climate of the organizations and the location or the furnishings of a respondent's office may be one indicator of the status of the respondent within an organization" (Yin, 1984, p. 85). According to Stake (1995), the case study observations should "develop vicarious experiences for the reader, to give them a sense of 'being there', the physical situation should be well described" (p. 63). I took copious notes regarding the agency environment throughout my time at each agency. The meaning and significance the observations were interpreted to inform other data and illuminate the setting for accreditation as a service delivery model.

Cross-Case Analysis

Analyzing data across cases increased understanding of the accreditation phenomenon. According to Stake, "understanding the phenomenon requires knowing not only how it works and does not work in general, independent of local conditions, but how it works under various local conditions" (Stake, 2006, p. 40). Findings and themes across cases were identified to show similarities and differences between the cases and examined site-specific experiences to present an understanding of the aggregate (Stake, 2006).

Summary

The mixed methods multiple case study research design for this study explored the complexities of the accreditation process at children's mental health agencies. It examined accreditation from the agencies' perspectives with various data sources

Towards the first aim of this study, in-depth qualitative interviews asked key informants about the agency's decision to pursue accreditation, to understand if policies that recognize accreditation or other factors influenced their decision to pursue accreditation. Focus group participants were asked how they first knew that the agency was pursuing accreditation to further understand the agency's motivation for pursuing accreditation.

To inform the second aim of the study, Glisson's measure on organizational social context, along with interview and focus group questions about the accreditation process, were explored. The organizational social context instrument, as part of the quantitative survey, generated a profile of each agency's organizational culture, climate, and work attitudes to be compared to a nationally representative sample of other mental health agencies. Limited observations at each agency also provided a context for organizational culture, climate, and attitudes. To understand agencies' experiences, interview and focus group questions asked participants about their involvement in each main step of the accreditation process, such as the self-study, site visit, and responding to the pre-commission report, their experiences with each aspect of the process and the challenges and benefits. The review of documents, including the self-study and pre-commission report, augmented and triangulated these data. Together, these quantitative and

qualitative data informed how organizational social context may influence an agency's experience with accreditation.

The first and second aims both inform the third aim of this study. Focusing on the third aim, the interviews, focus groups, and surveys asked similar questions regarding employees' perceptions regarding what has changed as a result of each aspect of the accreditation process. They were categorized as structural, process, and outcome indicators of quality. The review of documents related to the history of agency and the accreditation process were examined when participants referred to them during the interviews and on the surveys. Limited observations at each agency looked for structural changes that may have been made in order to meet accreditation requirements.

Each source of data in this study provided a rich description of the complexities of the accreditation process from the agencies' perspectives. The pursuit of accreditation affects agencies and this study focused on how these changes may improve services and outcomes.

CHAPTER FIVE: RESULTS FROM CASE STUDIES AND CROSS-CASE
ANALYSIS

This chapter presents the results from all five cases and the cross-case analysis.
The five agencies in this study were located in four different states, provided a
combination of different mental health services, and varied in size, from nine to 118
employees (Table 5.1).

Table 5.1 Selected Cases and Data Collected

	Agency #01	Agency #02	Agency #03	Agency #04	Agency #05	TOTALS
COA Service Standards	Group Living Wilderness and Adventure-Based Therapeutic Outdoor Services	Emergency Shelter	Group Living	Counseling, Support and Education Services Family Preservation	Residential Treatment Outpatient Mental Health Foster Care Adoption	
# Employees	104	9	15	57	118	303
# Survey Respondents	32	8	9	2	32	83
# OSC Surveys	32 (1 excluded)	8 (1 excluded)	9 (2 excluded)	2 (2 excluded)	31 (2 excluded)	82 (8 excluded)
# COA Surveys	31	7	8	2 (2 excluded)	30	78 (2 excluded)
# Interviews	9	3	3	5	9	29
# Focus Groups	2	0	1	0	4	7

For the quantitative data, a total of 83 employees returned the surveys, with the
response rate ranging from 3.5% to 88.8% at the five agencies. Several surveys were
excluded from the analyses for several reasons; due to missing data (two OSC excluded
from agency #03 and two OSC excluded from agency #05), random responses (one OSC

excluded from agency #01), low response rate at the agency (two OSC excluded and two

COA surveys excluded from agency #04), or were submitted too late to be included in the

analyses by the research team at the Children's Mental Health Services Research Center

(CMHSRC)(one OSC excluded from agency #02). Table 5.2 summarizes the T-scores,

Table 5.2 Results from the Organizational Social Context Survey

Domain	OSC Scales	Agency #01		Agency #02		Agency #03		Agency #05	
		T-Score	Percentile/ Standard Deviation	T-Score	Percentile/ Standard Deviation	T-Score	Percentile/ Standard Deviation	T-Score	Percentile/ Standard Deviation
Culture	**Proficiency**: Expectations that service providers will place the well-being of each client first and the providers will be competent and have up-to-date knowledge	53.6	61%	70.7	98%	55.6	70%	56.9	73%
	Rigidity: Service providers having less discretion and flexibility in their work; limited input into key management decisions; and being controlled by many bureaucratic rules and regulations	65.7	94%	68.4	96%	75.4	99%	66.2	95%
	Resistance: Expectations that service providers will show little interest in change or in new ways of providing service, and that service providers will suppress any opportunity for change	74.8	99%	68.7	96%	65.7	94%	73.7	99%
Climate	**Engagement**: Employee perceptions that they are able to personally accomplish	46.9	34%	51.1	55%	50.6	50%	44.3	27%

	many worthwhile things in their work, remain personally involved in their work, and be concerned about their clients							
	Functionality: Employee perceptions that they receive the cooperation and help from coworkers and administration required to do their job, have a clear understanding of how they fit in, and can work successfully within their organizational unit	50.2	50%	75.7	99%	38.0	10%	59.4	82%
	Stress: Employee perceptions that they are emotionally exhausted from their work, pulled in different directions, and unable to get the necessary things done	59.6	82%	47.5	39%	66.5	95%	58.8	79%
Work Attitudes	**Morale:** Characterized by an individual's satisfaction with his/her job and his/her feelings of commitment to the organizational unit	54.2	7.9	64.1	4.8	48.9	12.2	54.4	11.1

percentiles, and standard deviations for the Organizational Social Context's culture (rigidity, proficiency, resistance), and climate (stress, engagement, functionality) that affects employees' work attitudes (morale). A T-score of 50 was the mean of the national sample of mental health agencies with a standard deviation of 10. While culture and climate were organizational level constructs, morale was an individual level construct. According to the CMHSRC research team, T-scores for morale were computed by first subtracting the average national morale score and then dividing by the standard deviation obtained from the national sample. The individual T-scores were then averaged for each agency and their means and standard deviations were reported.

Regarding organizational culture, the four agencies with analyzed quantitative data seemed to be slightly above the mean in proficiency but were also highly rigid and highly resistant. For organizational climate, the agencies were near or slightly below the mean for engagement, while the score for functionality ranged from the 10th to the 83nd percentile. The scores also showed that the four agencies had relatively stressful climates. The morale at all five agencies were generally high, with the mean T-scores ranging from near to one standard deviation above the mean (64.1 to 48.9).

The number of interviews and focus groups depended on agency size and structure and employee availability. Three to nine interviews were conducted at each agency, totaling 29 across all five agencies. Although the key informants varied, they often included the Executive Director, QI Director, and program directors. Focus groups with direct care workers, such as childcare staff and social workers, were also conducted, ranging from zero to four focus groups sessions at each agency, totaling seven groups across agencies. Each focus group session had two to five employees. All employees are referred to as female throughout the analyses for the sake of readability and confidentiality. Reviewing documents such as the agency's Performance and Quality Improvement Plan, the Pre-Commission and Final Accreditation Report from COA supported what the employees shared during the interviews and focus groups.

Agency #01

Nestled into a national forest, agency #01 is surrounded by pine trees and sprawled out over 1000 acres. Trees with branches still bare from the winter line both sides of the dirt road that leads into the agency's campus and a horse roaming outside of

the stable is the first to greet visitors. This setting is fitting since the agency provides wilderness and adventure-based therapeutic outdoor services, as well as group living services, which include behavioral health services for youth experiencing behavioral health issues. While a few children are referred from the state department of social services, most of the children are placed privately by their families. This public state agency with approximately 100 employees began over 200 years ago when a private estate was dedicated to serving orphaned children. Given its long history, the agency is well-connected with the surrounding community. The agency hosts local pageant, an annual town festival, and is seeking to rent out some facilities for community use.

Several years ago, before the current Executive Director and Quality Improvement (QI) Coordinator came to the agency, they had applied for accreditation with COA but the process was not completed. In fact, they were not even aware of the previous application until the QI Coordinator contacted COA and found out that the agency had not even submitted a self-study at the time. The agency applied for accreditation again in the spring of 2007 and successfully achieved accreditation almost two years later. This could be considered an initial application for COA.

In-depth interviews were conducted with the agency's QI Coordinator, who led the accreditation efforts, the Executive Director, in addition to seven other members of the executive team who were asked to take the lead on responding to certain accreditation standards. Two focus groups, one with two and the other with three employees, were conducted with other direct care staff who were also active in the accreditation process. The QI Coordinator, who was my liaison throughout the process, along with the Compliance Clerk took me on an extensive and informative tour of the agency's grounds

and facilities. I also reviewed the self-study that the agency submitted to COA, as well as

the Pre-Commission Report and the agency's response to the PCR.

To collect quantitative data, surveys were distributed at a reception that I

advertised and hosted with refreshments. Surveys that were not completed during the

reception were placed in employees; mailboxes, along with a labeled stamped envelope

to return directly to me. Thirty-two employees (out of 104; 31%) completed the

Organizational Social Context survey and 31 (out of 104; 30%) out of those 32

employees also completed the portion of the survey with questions developed for this

study. One of the OSC surveys was excluded in analyses due to inconsistent response

patterns that suggested random responses.

The OSC data revealed that agency #01's organizational culture had a proficiency

level slightly above average and was highly rigid and highly resistant (Figure 5.1).

Regarding organizational climate, their level of engagement was slightly below average,

their level of functionality was average, and their level of stress was above average

(Figure 5.2). The morale at agency #01 was slightly above the mean of the national

sample (Table 5.2).

.   The agency's organizational social context profile reflected characteristics that

could have affected their experience with accreditation both positively and negatively.

For example, the relatively high level of stress at agency #01 could have been related to

the frustration some staff felt during the process and the high work load that may have led

to the agency needing to extend their self-study deadline. The high levels of rigidity and

resistance along with a low level of engagement could possibly have been connected to

some employees' skepticism about the impact of accreditation. In contrast, the agency's
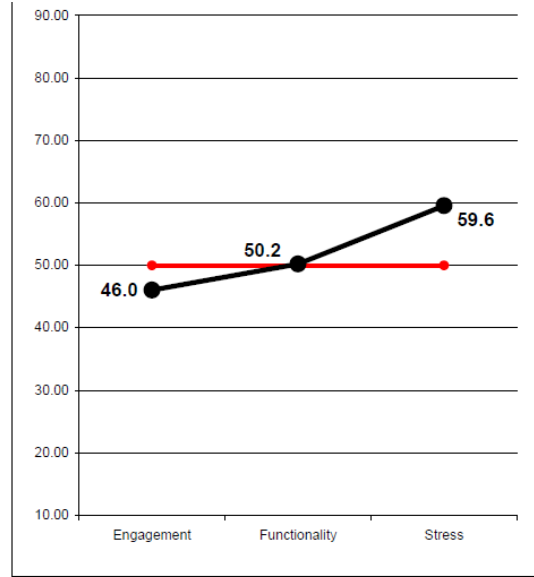
Figure 5.1 Agency #01 Culture Profile
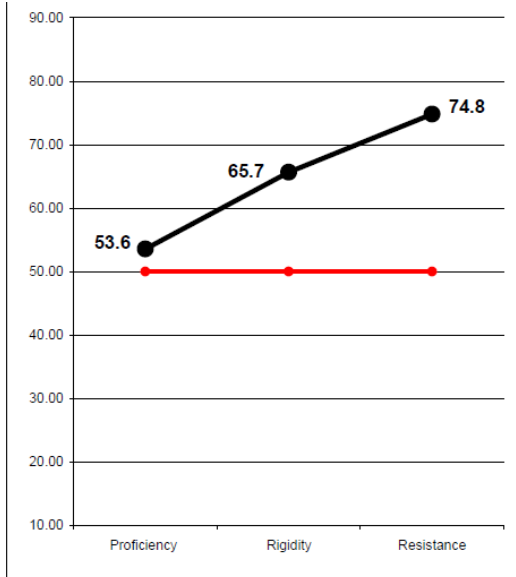
Figure 5.2 Agency #01 Climate Profile

slightly higher than average levels of proficiency, functionality, and morale may have associated with some employees' positive perception of accreditation as a learning experience.

The employees at agency #01 were very warm and gracious. The QI Coordinator and Compliance Clerk greeted me with refreshments and also gave me an office to use during my two and a half days at the agency. None of the employees were suspicious or worried about retaliation based on their responses. They seemed to be candid about their thoughts on accreditation, even if they had some criticisms.

Motivations for Pursuing COA Accreditation

At agency #01, the decision to pursue accreditation was made by the Executive Director. She said that they chose COA over other accreditors because it "fit best" for this agency. As the Executive Director said, "…the accrediting body needs to line up with

78

who you are, and for the most part COA has done that, and that's why we selected that particular body." The QI Coordinator also stated that,

> What we want to focus on is how we provide our services. And that's where, in my opinion, COA is unique. COA, when it was established in the '70s, it was set up with that in mind: The service provision. Best practices. So, to me, there is no decision.

The Executive Director added that the Joint Commission uses a medical model while the Commission on Accreditation of Rehabilitation Facilities (CARF) focuses on rehabilitation. The QI Coordinator also said that Educational Assessment Guidelines Leading towards Excellence (EAGLE) accredits faith-based organizations, which does not apply to this agency.

While some reasons for pursuing accreditation were made public to the employees by the agency Executive Director, other reasons were kept private and not shared with the agency at large. The agency leadership sought to use accreditation to further professionalize the agency. The employees shared that they were pursuing accreditation to improve services and signal distinction in their field to find more funding opportunities.

Professionalizing the agency: "…it is a greater force…"

The Executive Director's main goal was to use accreditation as a tool to make the changes that she saw were necessary in order for the agency to evolve and become more professional.

> Particularly because there was enough old guard here still that said, 'You know we've just been doing these things the way we've been doing them all along, and it's working out okay.' It really wasn't, but they didn't know any different… But rather than try to take this thing on by myself, make it kind of my crusade or

79

whatever, I said, 'All right. We'll bring accreditation into this.' So, it no longer becomes just us, or just me, but it is a greater force if you will.

She felt that the reasons for the changes needed to be larger than herself, although this was not made public to the employees. The Executive Director had worked at accredited organizations in the past and saw how accreditation increased the level of professionalism and detail that went into organizations' operations. Given these experiences, the Executive Director came to the agency several years ago with the plan to pursue COA accreditation.

Improving services: "…it has forced us to be consistent…"

Most of the employees cited that they thought the agency pursued accreditation to improve services by bringing internal as well as external consistency. One of the directors said that accreditation could make things better through the process of internally reviewing what was being done at the agency: "I was all for it. I think it is only going to make us better. It'll bring some credibility to the program and…make us better as far as having to review all of our processes and the way we do things." Another director stated that, prior to starting the accreditation process, policies and procedures were not documented and accreditation "has forced us to be consistent across the board with quality of care."

Another employee said that accreditation could also bring external consistency, by putting the agency in line with others in the field. For instance, one employee said that accreditation

> …gives a stamp of approval and like I said earlier, that does not say that we have
> not been doing this all along, it is just that some other governing agency is saying

that you are now in line with hundreds of other agencies who do it this way and this is the way that it is acceptable.

Another employee echoed, "I think that the agency pursued accreditation to be able to, not necessarily be competitive with other residential homes, but to sort of bring us in line with the other residential facilities and, bringing consistency with policies across the board."

Signaling distinction: "....you'd buy a Cadillac."

Compared to being in line with other agencies, several the employees mentioned that the agency sought accreditation to signal distinction among other agencies. One employee thought that the agency pursued accreditation in order to enhance the "stature of the agency" since "accreditation is important for the bigger players in mental health" and it may also "enhance agency reputation." Others mentioned that accreditation may "increase credibility" of the agency and "improve the agency's image." As another employee said, "[agency name] has always had a pretty good reputation for the services that we provide and to now have gone through this rigorous procedure that we have gone through then I think that does make use look even better than we did before."

The QI Coordinator thought that signaling distinction with accreditation may affect clients' decision to choose this agency. Almost all of their clients at are privately placed by families.

> Families can trust us to provide the best services to their kids when they are placed here because they realize it's not just us. It's not just the fact that we're a State agency, but you know, we actually will be recognized by a national body…once we put out the word, it will become part of our intake process...if you could get a Cadillac for the same price as a Taurus, what would you buy? You'd buy a Cadillac.

A couple of other employees mentioned that there is a "prestige factor" to achieving accreditation, which could bring national recognition.

Funding opportunities: "...it almost becomes a fight for survival."

Signaling distinction could also help the agency obtain more funding and several employees mentioned that they thought that this was a motivating factor. For example, one employee said that accreditation could help the agency survive, especially during the state budgeting process.

> …being a State agency, it never hurts to have some good trophies hanging on your wall, because for State agencies, especially small ones, it's a fight for every dollar during the budgeting process every year. With the economic trends, it almost becomes a fight for survival.

The Executive Director shared that the agency lost one of its funding sources when the funder made accreditation a requirement for funding eligibility. In fact, one of the first phone calls that she made after receiving the news that they had successfully achieved accreditation was to the funders. Several employees also specifically mentioned this funding source as a reason for seeking accreditation.

Experience with the COA Accreditation Process

The QI Coordinator described the self-study process as being analogous to "putting a mirror in front of the agency and saying, 'This is how we see ourselves, how we look to ourselves,' and then you compile it, and you get it to COA so that they can see a picture of us." The responsibility for coordinating the efforts fell on the QI Coordinator. She assigned members of the agency's executive team to lead their department's work on certain parts of the self-study. Several employees described the self-study as a "long,

difficult process", "frustrating", "grueling", a "headache." A few employees specifically stated that the self-study was the most difficult part of the accreditation process. The quantitative data showed that the employees were split about their experience with the self-study process. While 14 employees (out of 31; 45%) thought the process was burdensome to some extent (7=somewhat burdensome, 5=burdensome, 2=extremely burdensome), 16 (out of 31; 52%) employees indicated that the process was not at all burdensome and one was not aware of the process.

Following the self-study, the QI Coordinator was the point person for COA's two peer reviewers who spent two and a half days at the agency for the site visit. Although the anticipation of the site visit was described as "nerve-racking" and "anxiety-provoking", most employees actually found it to be a very pleasant experience. A few employees shared that they were worried that the site visit would require answering difficult questions and would feel like an inspection, particularly given how grueling the self-study process was. In contrast, some stated that it was the easiest part of the entire accreditation process. This was also reflected in the survey data. Most (28 out of 31; 90%) indicated that the site visit process was not at all burdensome, while two employees indicated that it was somewhat burdensome and one employee thought it was extremely burdensome.

One employee was more critical of the site visit and shared that she did not feel that the site visit confirmed that what was presented in the self-study was actually being done. She particularly mentioned the interview with one of the peer reviewers did not seem very in-depth.

> …she had a few questions, but she didn't really ask a lot. And all I'm saying was that they were supposed to have already read the information, so I would think

that they would have known specifically when they were talking to us what to ask… As a matter of fact, I questioned, you know, "Does she know what she's doing?"

Within only a couple of weeks after the site visit, the agency received the Pre-Commission Report with recommendations from the peer reviewers. Most of the recommendations were regarding more evidence of PQI activities and more information regarding client restraints. The QI Coordinator was responsible for responding to the less than a dozen comments on the PCR from the peer reviewers within 45 days. The QI Coordinator said that there were recommendations that she was expecting but was surprised that they were not on the PCR.

When asked about each part of the accreditation process, the employees shared the challenges of understanding and using the accreditation standards, the time required for the self-study, as well as the benefit of gaining new perspectives as a result of undergoing accreditation.

The standards: "… we were about to pull each other's hair out…"

The QI Coordinator described COA's 8th edition standards and COA's contextual accreditation process:

> …. the standards challenge you, but it doesn't tell you explicitly every single time, "This is what is expected." It's more of a challenge to, "This is what we're looking at. Now, how does your agency fit in? How do you make this fit into your agency? And then show us how you think that you meet what these standards are saying?"

Although the contextual approach by COA gave the agency flexibility when responding to the standards, one of the employees expressed that the standards "were vague and general and more specificity would have been easier for us to try and formulate the policies…" Another employee, who was new to accreditation said, "Oh, my

goodness...we were about to pull each other's hair out for awhile, but it is a tough

process…"

In general, most found the accreditation standards to be relevant and stated that

they seemed to match what they were doing at their agency. One employee said that

COA's standards helped them identify areas for improvement.

> I thought they were reasonable. I felt bad that we as an agency didn't have quite of
> few of those things already in place. And if they were in place, it was not outlined
> to the degree we really needed it to be.

The employees who worked on the human resources and financial management standards

shared that their jobs already required them to demonstrate compliance with state

standards. As one of the directors said, the state standards were generally more rigorous

than COA's standards and "…being a state agency comes first. I will always go with

what the state requires." Another director said that COA accepted the information when

she referred to a proviso or a state law.

Some staff shared that COA updated their standards on the COA website during

the self-study process and they were responsible for keeping track of the changes,

creating some additional work for the staff. The QI Coordinator also shared that she

noticed some mistakes in the standards including incomplete sentences that made some of

them unclear. When she notified COA, COA acknowledged the mistakes and clarified.

Another employee questioned the validity of the standards and asked, "What are the

standards based on?"

Time and opportunity costs: "I can't do my job because I always have to do this COA…"

Most of the employees expressed that the main burden of the accreditation

process was how time consuming the self-study was. One member of the executive team

shared that it took a lot of time to write 10 to 12 pages of narrative in response to the set of accreditation standards that she took the lead on. Most said that making time for the self-study was the most difficult part. In fact, some said that and that the self-study took away from their other responsibilities. For example, one employee said that the entire agency's intake process had to be put on hold in order to meet the self-study deadline. This meant that children were not admitted into the agency's programs for a couple of weeks during that busy time. The QI coordinator shared that she had to cancel crisis response training for new staff due to the self-study due date. Other staff mentioned that some routine paperwork was delayed due to the self-study.

Others also expressed that balancing the self-study with their other duties was burdensome. The QI Coordinator shared she heard comments from staff, "I can't do my job because I always have to do this COA, or there's something else about COA." Since they did not have a choice in completing their other duties, the self-study was above and beyond their regular responsibilities. As a direct care staff explained, "Honestly, the job title that we have is very brutal, is very demanding, very time consuming. It kind of goes with the territory to have a full plate and then have a side entree added on top of that." Some staff shared that they worked overtime, worked on their off time, and took work home to complete the self-study.

The burden of the self-study made it difficult for the agency to meet COA's submission deadline. The agency requested a six month extension from COA due to difficulties completing it and personal issues that required the QI Coordinator to take time off. Those employees who led certain sections of the standards found it challenging to have their parts of the self-study ready in time. While many of the employees that

participated in the in-depth interviews and focus groups shared about the time burden of the accreditation process, most indicated on the survey that they agreed (13 out of 31) or strongly agreed (1 out of 31) with the statement, "The accreditation process enabled this agency to better use its internal resources (e.g. finances, people, time, and equipment)."

New perspectives: "...it was a great learning experience for me."

During the accreditation process, many employees gained new perspectives about their work as a result of reviewing their programs. The survey data showed that most employees agreed (17 out of 31) or strongly agreed (4 out of 31) with the statement, "The accreditation process is a valuable tool to implement changes." One employee wrote on the survey, "Areas of weakness within the agency have been reviewed for performance and benefit evaluation." As one member of the executive team who had limited prior experience with accreditation stated,

> For me, it was a learning experience. You know, like I said, I've been a part of, you know--being involved with an agency that was accredited and with this being new to our agency, again, we had some things in place, but it's just a matter of raising the bar. It gave me an opportunity to actually have hands-on experience with writing those policies and those procedures, and like I said, I feel like it was a great learning experience for me. It helped me see the other side of the table, so to speak, as far as how things are done.

For this director, using COA's standards during the self-study process and reviewing what policies and procedures were needed opened her eyes to new ways of doing things.

Before starting the accreditation process, the Executive Director described that the agency was functioning with a "mom and pop mentality."

> When you start, when you're a two-person operation, you don't really need policy and procedure necessarily. You don't need those kinds of structures in place, because you just do things the way you do things. But as you expand, as you grow, that sort of structure becomes very, very important.

This was also reflected in the survey data. Most of the employees (21 out of 31; 68%) responded that they agreed (17 of out 31) or strongly agreed (4 out of 31) with the statement, "The accreditation process is a valuable tool to implement changes." Nine employees (out of 31; 29%) indicated that they were neutral or had no opinion and one disagreed.

The site visit also helped the agency gain new perspectives. One of the directors shared that, during the interview with the peer reviewer, it was helpful to hear about the reviewer's agency's experience with the accreditation process, from one professional to another. As another employee said, the peer reviewers asked good questions and that she benefited from others' points of view. Another employee said that she appreciated knowing where the agency stood among other agencies. One employee said it was helpful that the reviewers found some things that were missing from the client files while reviewing documentation. One of the direct care staff members coordinated parents and children to be interviewed by the peer reviewers. She shared that it was encouraging to learn more about what the parents thought about the services their children received. The site visit with the peer reviewers highlighted areas for improvement and also gave the agency a perspective on the field.

Perceptions of the Impact of the COA Accreditation Process

Most employees had overall positive perceptions about the impact of the COA process. As reflected in the survey data, most (24 out of 31; 77%) felt that the accreditation process improved the services they delivered on some level (14=somewhat improved care, 9=improved care, 1=improved care a lot), while seven employees (out of 31; 23%) indicated that did they did not think the process improved care at all. Several

employees perceived accreditation to be the norm for agencies such as theirs and thought

it was a helpful process. One of the direct care staff said, "I don't see how an agency this

size would not have been [accredited]." Another staff member added:

> We can review ourselves, and we can come up with things here and do it like it had been done the first 200-some years and continue to have done those things, but with this, it brings in other folks who have a more unbiased opinion--who can give us a real, a real idea of what's working…not just what's working here, but what's working far outside of our gates--what's working, you know, just in society as well. It just opens up so many doors for us to improve ourselves. And I think it's a good feather to have in your hat…

One employee said that accreditation will "keep us on our toes" because another entity is

watching.

When asked if undergoing accreditation has affected the agency's adoption of

evidence-based practices, the QI Coordinator referred to the client outcome data that they

began to collect due to COA's requirements. She described that the agency uses these

data as evidence to support their practice with clients, though it did not seem to involve

utilizing the research literature. She did mention that she would consider their use of the

manualized Therapeutic Crisis Intervention (TCI) training for staff as an evidence-based

practice.

According to the QI Coordinator, the effects of the accreditation process depend

on what the agency does with it:

> When the agency has totally bought into what accreditation is, then the clients are going to see it. It's going to affect the culture. It's going to permeate through everything and the agency is going to be able to say they are proud that they are accredited, and they're not just going to show the plaque on the wall. It's going to permeate the society and culture of that agency.

Many of the employees shared that undergoing accreditation mostly affected process

indicators of quality, such as policies and procedures and increased communication

within the agency, while some also noticed some early impacts of accreditation on client

outcomes. A few other employees were skeptical and questioned the value and the impact

of accreditation.

Documentation of existing policies and procedures: "Writing down what we do"

All of the employees I interviewed shared that responding to the accreditation

standards during the self-study process led to the documentation of existing agency

policies and procedures. This was useful for training new staff and for succession

planning, particularly considering the high turnover rates in this field. For example, one

of the products of the self-study was a training manual for one of their programs, which

as staff described, involved "writing down what we do." Some direct care staff added that

this documentation made policies and procedures more official, succinct, and formalized.

One staff member shared, "It did bring some of the stuff closer to the front that may have

gotten so redundant with and maybe not as sharp with, but it brought it back to the front."

Another direct care staff joined the agency in the midst of the self-study process and she

shared that it helped her learn her new job.

> … it was good, because I had just started, and it gave the agency time--you had to
> put down procedures and policies that before, they didn't have any documentation
> of half the things that we do. So, as I came along to prepare for COA, you had to
> get those documents down in writing, so it helped me learn my job description
> quicker as well as people that I supervise.

Another employee mentioned that organizing documentation for the self-study

improved client record keeping, making information easier to find and more organized.

Another product of the self-study was an agency-wide employee handbook of policies

and procedures. This was already in the works but the self-study process pushed them to

complete it. This documentation helped put structures and processes in place at the agency.

New and modified policies and procedures: "If staff improve, then the children will improve."

In addition to documentation of existing policies and procedures, the self-study process also led to the institution of new policies and procedures. Several employees gave various examples. The agency established a new appeals process in response to COA's client rights standard that addressed client recourse when discharged from service. One of the directors shared how this new appeals process led to changed client outcomes.

> Yes, and we've had at least two of those that came and they did well for a while, then they sort of regressed to the point where they were asked to leave. And they appealed and they came and made the case. And the decision was made to give them another opportunity, another chance. And they came in and did everything that they needed to do, and was successfully discharged.

Employees gave several examples of other new policies and procedures, such as aftercare procedures, which as one direct care staff expressed has benefited the staff: "It's good for morale to let them know that once students do leave, even if they leave unsuccessfully that some of them, most of them have benefited from their time here." COA's standards on ethical practice also required the establishment of an agency-wide fundraising policy and conflict of interest policy which were not in place prior to undergoing accreditation. A process for evaluating client outcomes were also put in place due to the accreditation requirements. In addition, the Executive Director shared that she uses client outcome data at staff meetings to motivate staff by showing them how they are making a difference. As one of the program directors echoed, "If staff improve, then the children will improve."

The self-study process also led to the modification of some policies and procedures. For example, COA's group living services standards required that the client be present during searches for contraband items, which was not the case prior to the self-study. A couple of other employees also said that this review and modification of policies and procedures helped eliminate some forms and documentation. In fact, one direct care staff said that this streamlining led to them having more time to spend with clients.

> I think it's helped, like I said, open up more time to actually spend with the students and their issues. It has helped us streamline a whole lot of things, if nothing else, the different amount of paperwork that we have to do. We have a tremendous amount of paperwork, and at that time, we had maybe five or six forms for one particular thing that had to be documented several different times. And those things have been consolidated. Everything is pretty much come to be uniform under those standards, so it's helped us out with that.

Upon reviewing the PCR, it revealed that COA also required that policies and procedures be more clear with additional information to confirm follow through, including evidence that the data for PQI and RPM were actually being reviewed, and the agency responded with meeting minutes. The reviewers also asked for more details regarding client restraints under the behavioral management standards. The agency responded with a revised restraint incident form that now reports additional information regarding who is involved, how often was the incident happening with a particular client or a particular staff, particular date, particular weekend, assessing, and doing some type of review about what was happening. As one of the directors commented, "We had it, but we weren't following up on the reviews and stuff of that nature." The QI Coordinator shared that closer tracking of client outcome data in the past few months showed that an increased proportion of their clients have been meeting their goals towards discharge.

Increased communication: "…it forced everyone to come together…"

Several employees pointed out that the self-study process led to more communication throughout the agency. Responding to some of the standards required various departments across the agency to work together and learn about each other. For example, the group living and wilderness programs both needed to communicate with the intake department since all the clients in the programs come through intake. Many other standards, such as training, behavioral management, and client rights affected all programs, thus communication was necessary to respond to them.

> Because, as an agency, since I've been here I've found that the departments really doesn't share information with one another…. And, so as a result of the self-study, and compiling the information and everything, trying to get accredited, it just sort of forced everyone to come together to communicate.

In addition to interdepartmental communication, the self-study process also led to increased communication with the agency's governing board since COA requires that policies and procedures be approved by the Board. This led to overall increased board involvement at the agency.

The survey data showed mixed results. A couple of employees responded on the survey, "It has opened doors for better departmental communication." Another wrote, "Every department works more as a team." While many employees (12 out of 31; 39%) agreed (9 out of 31) or strongly agreed (3 out of 31) with the statement, "The accreditation process enabled the motivation of staff and encouraged team work and collaboration,' many others (13 out of 31; 42%) were neutral or had no opinion. In addition, several employees (6 out of 31; 19%) disagreed (4 out 31) or strongly disagreed (2 out of 31) that the accreditation encouraged team work and collaboration.

Accreditation skeptics: "…like waxing a rusted car…"

Despite mostly positive perceptions of the accreditation process, some were

unconvinced about its impact. One employee responded to the open-ended question on

the survey.

> The accreditation process does encourage the agency to improve its policies, set clear guidelines for practices and set standards for staff. This appears to be on paper only. Overall, changes have been worse not better. Maybe lack of leadership, not accreditation.

Another employee questioned if accreditation would benefit the children the agency

serves and also raised the issue of accreditation being money driven by the accreditors.

> I don't see what the kids are getting…What does accreditation do for them? Accreditation, in my opinion, and this is just my opinion, accreditation is money-driven and it loses sight on the children. It should be about the benefit for the kids, these at-risk kids. It is my understanding that the agency has to pay a large sum of money to become accredited now…I do not have any proof of that, now, but I am not naïve enough now to think this is all that this accrediting body is doing this just because…What do we get in return other than the standards to say we will insure that all of the rooms have doors, that the children have privacy; we have been doing that all along because it is a basic quality of life need for children… And I know that there may be something else that we can get from it, but I don't see it.

She expressed that she has not seen accreditation tangibly benefit clients but felt that

accreditation does have a role in affecting clients. Similar sentiments were echoed by

another employee as she questioned if accreditation would improve quality of care:

> I wonder is it all about money and not really about the care and quality?... Because the agency has to pay COA…I think we've just bought ourselves a piece of paper, if we get it. I don't know that we bought the quality that we need."

> Another employee felt that accreditation also diverted attention from the clients'

behavioral issues and stated that accreditation is

> like waxing a rusted car…there were some more issues as an agency that we should be focused on rather than… I mean I think accreditation is important. I just didn't think that was the time to do it… we weren't doing behavior management the way we should be doing it. And, so pulling folks away to do

things like COA accreditation at a time when we really need to be focused on getting the kids/students behaviorally where they need to be, was I thought not a good use of the resources at the time.

From this employee's perspective, she did not expect accreditation to affect clients'

behavioral issues but felt that the behavioral issues should have been prioritized before

accreditation. Another employee questioned if accreditation would matter to parents of

the children served at this agency and questioned the value of accreditation.

> …I'm still not real sure about it. I am still not because in my mind because of the type of agency that we are, and because we have been here for over 200 years and we have not been accredited, I do not think that parents will look at that…But I think when there are stressed times, they are just looking for a place to place their children. I am not sure they are just going to look to make sure, okay, yeah, they're accredited…Maybe if they understood what it meant. Maybe it would be a little different. But I am not sure. I guess I will just have to see.

This employee also candidly expressed, "…I disliked the whole accreditation process,

but… I have an appreciation for it now…" The full impact of the COA accreditation

process may become more evident with time.

The Accreditation Decision

The agency received news that it had successfully achieved accreditation on the

last day I was there for data collection. The QI Coordinator and Executive Director

allowed me to be present when they returned COA's telephone call to receive their

accreditation decision.

The supervisor of COA's Accreditation Coordinators (AC) called on behalf of the

agency's assigned coordinator since she was out of town. The COA AC supervisor first

announced that the agency has become reaccredited. The QI Coordinator and Executive

Director corrected her that it was their initial accreditation. The COA AC supervisor

congratulated the agency and the QI Coordinator thanked the COA AC supervisor. There was excitement about the news as well as relief.

After the phone call, the Executive Director congratulated the QI Coordinator and said that she would immediately contact the funder that now requires accreditation and also use this news to advocate for money in the legislature. They also discussed how to handle the media and QI Coordinator was reminded that COA will send the agency a PR packet. They will wait to notify the staff. They also discussed putting the logo on their website, the state website, and how to present their new status as a state entity with national recognition.

Agency #02

A bright, white wraparound porch with rocking chairs and children's toys adorn the entrance of agency #02. It was established in the mid-1990s when a community group contacted the state's department of social services regarding the need for a local children's home to prevent out of county emergency shelter placements. Two years later, agency #02 was established. Several years later, the agency received a new license, allowing them to serve up to 12 children. The agency cares for children from birth to age 17 that are referred from the state's child welfare authority. It remains a small agency, now with nine employees.

Their building was expanded several years ago with the help of another charity. Prior to the expansion, staff office space was shared with the children's living space and children ate gathered around the kitchen counter because there was no room for a dining room table. Now meals are shared around a dining room table and volunteers sometimes

come to cook meals for the children. Community volunteers are very active at the agency.

Most of the agency's décor was done by community volunteers, including various

themed decorative murals throughout the home and even matching curtains. Most learn

of the agency via word of mouth or newspaper articles and presentations the agency gives

at churches regarding identifying and reporting child abuse.

The agency applied for accreditation in the summer of 2007 and submitted the

self-study in less than a year. The site visit was conducted a few months later and they

responded to the Pre-Commission Report in the fall of 2008. A month after the agency

submitted their response, the agency received news from the Council on Accreditation

(COA) that the Accreditation Commission deferred their decision, indicating that it had

questions about the agency's implementation of and continuing performance with some

standards and requested further information. The agency then responded to those

additional responses from the deferral in the spring of 2009 and was awaiting an

accreditation decision when I visited.

Due to budget issues, several employees were recently laid off. I interviewed the

Executive Director who led the accreditation efforts, the case manager, and the direct

care supervisor as key informants. Focus groups were not conducted since I interviewed

three out of nine employees. In addition, the surveys were left for the employees along

with a stamped and labeled envelope to send back the completed surveys directly to me.

Eight of the nine employees completed Glisson's Organizational Social Context measure

and seven of those eight also completed the COA accreditation survey portion with

questions developed specifically for this study. One OSC was excluded in the analysis

since it was submitted too late to be included in the analyses by the Children's Mental

Health Services Research Center at the University of Tennessee Knoxville.

The data from the OSC showed that agency #02 had a culture that was highly

rigid and resistant, while also highly proficient (Figure 5.3). They also had a highly

functional organizational climate. Their level of engagement was average and their level

of stress was slightly below average (Figure 5.4). The employees also indicated attitudes

reflecting high morale at agency #02 (Table 5.2).

Figure 5.3 Agency #02 Culture Profile   Figure 5.4 Agency #02 Culture Profile
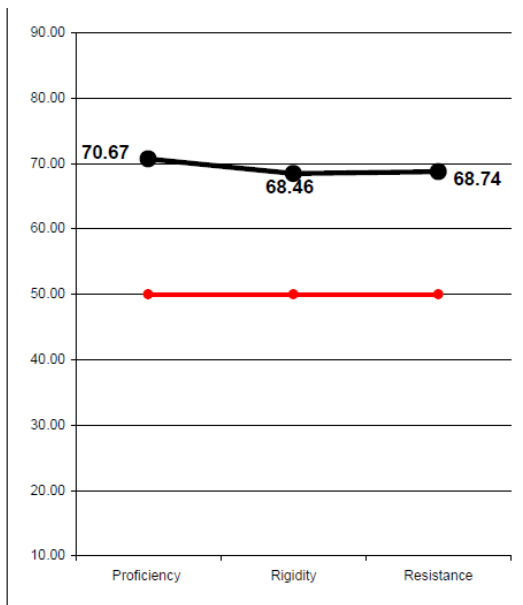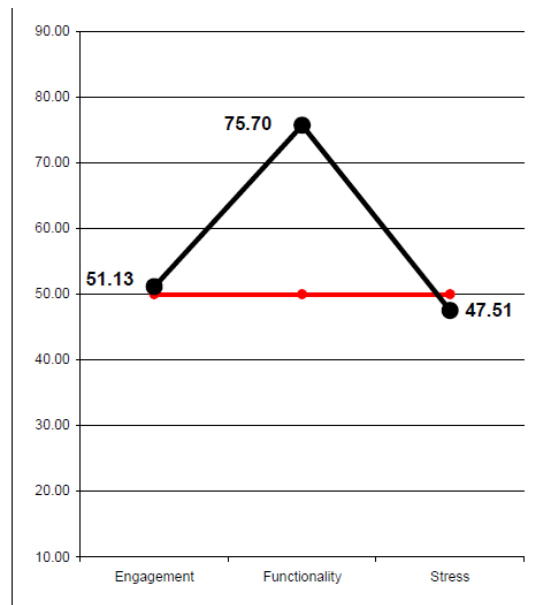
This organizational social context profile reflects characteristics that were not always

consistent with the qualitative data from in-depth interviews. For example, the OSC

indicated high rigidity and resistance but the qualitative data showed the agency's

flexibility in responding to COA's standards. Although the agency's accreditation

process was a long process with a deferral from COA, the OSC revealed a lower than

average level of stress. Consistent with the qualitative data, the OSC characterized higher than average level of morale. High levels of functionality, engagement, and proficiency may be related to the agency's positive experience of rising to the challenging of COA accreditation.

For the document review, I was allowed access to the self-study that they submitted to COA, the Pre-Commission Report, the agency's response, the Post-Commission Report which deferred their accreditation decision, and the agency's response. The Executive Director also gave me a tour of the agency as she generously shared her knowledge and her experiences. I was received welcomingly and very kindly during my day at the agency.

Motivations for Pursuing COA Accreditation

It was the Executive Director's decision to pursue accreditation and it coincided with the change in leadership at the agency. The previous Executive Director had looked into accreditation, but found that the process would take much longer than she had time, since she was anticipating retirement. In addition, the Board thought that they did not have enough money to go through accreditation and did not see its benefits. When the current Executive Director moved into her role (she was previously the case manager at the agency) in 2006, she presented accreditation to the Board again. The new Board Chair who also took the position the same year the current Executive Director did, was supportive of pursuing COA. Together, they were able to attain others' support.

The Executive Director said that she chose COA because she spoke with other agencies that were accredited by another accreditor but the agencies were not satisfied

with the help they received. She also looked into another accrediting body but they

accredit faith-based organizations, so their agency would not be eligible. She found that

"COA was the leading organization that everyone was going with." She said the COA

accredited agencies shared that it seemed to be worthwhile.

> It [accreditation] was not easy, but it was understandable. It was something that once you got started doing it you would be able to understand the reason behind it and it was not a bunch of paper pushing just to be able to say you did something.

The employees shared various reasons for pursuing accreditation, including using

accreditation as a platform for change, external validation and outsight, and funding

opportunities.

Platform for change: "...to make the changes that we saw that needed to be done…"

The Executive Director sought to use accreditation to make changes and

formalize the agency as she took on her new role.

> …a lot of different things that we wanted to formalize were not as smooth as we thought it should be here in the agency. We felt like that would be a wonderful way for us to do our own in-depth study of our agency. We could accomplish two things as they say with one stone. We could get the accreditation, but we would also be able to make the changes that we saw that needed to be done, as well as anything that came up under accreditation.

The direct care supervisor shared similar sentiments and felt that "it [accreditation] will

help us to see some things maybe where we were falling short that we could improve

on…" The introspection involved during the accreditation process was hoped to lead to

changes and formalization at the agency at a time of leadership transition.

External validation: "We would be under the, more or less, title of being the best ..."

Another reason for pursing accreditation at agency #02 was to gain external validation of being an accredited organization. According to the Executive Director, achieving accreditation would confirm the quality of their agency.

> We have a wonderful agency. We always thought we did. We wanted to be able to shout to the world that we have one of the best agencies and accreditation would be what allows us to be able to say that.

Similarly, the case manager said, "I've heard of placed being accredited. And with that, that meant that we would be under the, more or less, title of being the best." The employees hoped that achieving accreditation could give the agency distinction among other agencies in their field.

External oversight: "...you might get a little slack."

In addition to the external validation that accreditation could provide, accreditation also provides oversight. As the direct care supervisor said, "I think it [accreditation] basically kind of like holds the home somewhat more responsible too, I think it will be great." Having the external validation from accreditation may also increase accountability at the agency to uphold their status. Thus, oversight was another motivator.

> I thought with accreditation you would have to follow certain rules and guidelines and, like I said, we was already getting all this in training and stuff up front anyway, but with that, I think it really just keeps us focused, okay this is something you need to continue…But if you don't have nobody there kind of like overseeing you sometimes, you might get a little slack.

An accreditor's oversight may encourage the agency and its employees to improve services.

Funding opportunities: "…to be able to get the funding that was necessary to improve our agency…"

The Executive Director shared that the agency decided to pursue accreditation

because it is more often becoming a requirement for funding.

> Different agencies were going to a procedure that said they would not accept or
> not fund agencies that were not accredited…if we were going to stay in the top of
> our field and be able to get the funding that was necessary to improve our agency,
> I felt like we were going to have to do some more things and just kind of step up.

The case manager and direct care supervisor also mentioned that donors have asked if the

agency was accredited. They both mentioned that increased funding opportunities could

lead to more resources to higher more qualified staff.

> I understood that we could get people in to serve the kids on a more professional
> level…as far as people with higher degree, higher pay level…because of the
> funding maybe you could ask for, get some type of funding. That would enable us
> to pay, have a higher pay scale.

Accreditation may be necessary to bring much needed funds to the agency. The funding

could then be used to attract staff with more credentials. As the direct care supervisor

added, "So, we look for people that's caring, first of all, more than anything else. Well,

you have to have the ability to communicate and that too, but money, it just is the bottom

line. It makes a difference." The goal was to attain better staff with better pay.

Experience with the COA Accreditation Process

The Executive Director led the accreditation efforts at agency #02 and shouldered

most of the work. In preparation, she attended COA's accreditation training, as well as

their training on PQI. She wrote the narratives for the self-study while the case manager

helped with assembling some of the documentation for the self-study and site visit and

the direct care supervisor was an active member of the PQI Team that was formed during the accreditation process.

She shared that meeting COA's requirements and recommendations was a challenge. In order to find assistance, she had to be extremely resourceful and reach out to the community. As she described, "Being this small and having no money, we have to get out there and figure out who knows more than I do." She found volunteers to provide consultation and various trainings that they needed to meet COA's requirements during each phase of the accreditation process, but she also questioned if the costs outweighed the benefits of some of COA's requirements.

> I am already strapped for money and you are asking me how am I going to get the rest of my money to make my budget, but on the other hand you are saying go out and get this done and pay for this. So to me that was kind of just enough to make you want to pull your hair out.

Interestingly, almost all of the employees agreed (5 out of 7) or strongly agreed (1 out of 7) with the statement, "The accreditation process enabled this agency to better use its internal resources (e.g. finances, people, time, and equipment)." One employee indicated that they were neutral or had no opinion.

Self-Study: "…I was dreaming about paper chasing me."

All three employees that I interviewed found the accreditation standards to be relevant and that they applied well to their agency, but the Executive Director mentioned that it would have been helpful if they were more specific. While reviewing the standards during the self-study process, she also found some of the standards to be redundant.

> I kept reading and I am going, 'Isn't that the same thing? So what is the difference? I do not understand the difference between PQI 1 and 1.5 or 5.6. You know…or 4 and then 4.2 versus 4.4. I am not…isn't it all the same thing?'

The Executive Director shared that, because of the small size of the agency and recent layoffs, the other staff were not able to devote much time to help with the self-study. On the survey, the employees indicated that they were involved (6out of 7) or extremely involved (1 out of 7) in the self-study process. Most did not find it burdensome (5 out of 7), though one employee responded that it was somewhat burdensome and another found it extremely burdensome. The Executive Director described that it was time consuming and, in fact, she was so engrossed in working on the self-study that it actually emerged in her unconscious.

> …I was dreaming about paper chasing me. It was chasing me uphill and it was almost just right at my head and it was about to catch me, but I could at least see the top of the hill. I was trying to get there. It was that self-study."

She shared that she devoted at least three days a week to accreditation. She came in early in the mornings and stayed later in the evenings to complete the self-study, which was housed in several binders filled with documentation.

Site Visit: "...I did not feel like somebody was here trying to discover the worst of the worst."

For the site visit, two COA peer reviewers spent three says at the agency. The Executive Director said that the peer reviewers were very professional and helpful and that the visit went better than she thought. The Executive Director said that the employees were anxious beforehand but they had a very positive experience with the peer reviewers. This site visit experience was somewhat reflected in the surveys. More than half of the respondents (4 out of 7) indicated that they thought the site visit was not at all burdensome, but a couple others thought it was burdensome or extremely burdensome

and another employee responded that they were not aware of the site visit process. The

Executive Director shared that

> They [peer reviewers] really calmed us down…Because they kept saying we are
> not here to trick you. We are not here to fail. We are here to help you get the
> accreditation…so I did not feel like somebody was here trying to discover the
> worst of the worst.

The peer reviewers made the staff feel comfortable and shared a meal with the children.

Since it is a small agency, the Executive Director was interviewed several times

regarding various standards. The case manager was interviewed during the site visit and

the peer reviewers asked her about the agency goals, vision, and mission statement. She

also mentioned that the anxiety employees felt before the site visit turned out to be

"unnecessary stress" since it turned out to be a positive experience.

Pre-Commission Report recommendations

Following the site visit, the majority of the recommendations on the PCR were

regarding Performance and Quality Improvement (PQI). The agency did not pass the PQI

standards, mostly due to the lack of evidence regarding implementation of PQI, use of

aggregated data, and tools for chart review. Several recommendations also focused on the

implementation of Risk Prevention Management (RPM) as related to PQI. Another

concern was regarding financial management as the reviewers noticed that the projected

budget would lead to a deficit. Other issues brought up on the PCR were regarding

frequent verification of vehicle insurance and driver's licenses for employees and fire

drills being conducted during all three shifts. The reviewers were also concerned about

the projected budget shortfall and the status of a pending lawsuit against the agency and

the financial impact it could possibly have.

According to the survey data, one employee was not aware of the PCR but five others were "somewhat involved" to "extremely involved" in responding to the PCR. While four of the involved employees indicated that the responding to the PCR was not burdensome at all, one felt that the process was extremely burdensome.

Deferral of accreditation decision: "I don't think that they should continue to find, send, find, and send."

In late 2008, the agency found out that COA's Accreditation Commission deferred their accreditation decision. The Executive Director expressed that the Commission's concerns were similar to the recommendations on the PCR. "To me it was the same thing. I thought, 'If I sent you what you asked for, why am I still having to show you any anything under this particular [standard]?' The case manager shared that the agency responded to all recommendations on the PCR, but the deferral also made additional, different recommendations that were not on the original PCR.

> You correct whatever is it they're asking you to do, and you send that in and they come back…and they see that you completed everything they asked you to so, "I don't think that they should continue to find, send, find, and send."

In response to the deferral, the agency provided additional information regarding the implementation of PQI and RPM and provided updated status on the pending lawsuit. In some cases, document review revealed that the agency provided the same information it had previously provided in response to the PCR.

Perceptions of the Impact of the COA Accreditation Process

Overall, the employees at agency #02 indicated on the surveys that undergoing COA accreditation improved the care they provide. As an employee shared on the survey,

"It appears that we have better teamwork and committees have been formed to articulate and implement new and better strategies for our client's needs." One of the employees responded on the survey that accreditation has "helped the home to identify and characterize the things that we were already doing." All of the employees that responded to the survey agreed (4 out of 7) or strongly agreed (3 out of 7) with the statement, "The accreditation process is a valuable tool to implement changes." The Executive Director elaborated,

> We have a more formalized approach to present our services to the clients. As I said before, we were doing a great job. I have always been proud of my staff and the way they handle themselves and the things that they do. But, it was not as pulled together as it is now due to accreditation. Going through the accreditation I think for me personally was a wonderful experience simply because it gave us an opportunity to see what we had been doing, but also to embrace a better way of doing things.

When inquired regarding evidence-based practices, the Executive Director shared that she had done some of her own research on children's mental health in an effort to better meet clients' needs, though it did not seem to be a formalized process.

> I talked to a bunch of different agencies and I had to find my books over there, but I had gotten a couple of different book on mental health and the children's different tendencies, different things, the different perceptions children will have in coming in to foster care.

Executive Director said that, during the site visit, one of the peer reviewers provided extra consultation with PQI, which she said was the "biggest benefit" of the entire accreditation process because their PQI was "not focused enough." A PQI team was newly formed who then formulated a PQI plan for the agency. The main PQI goal that the employees discussed was regarding more frequent fire drills. The other PQI goal was regarding staff and client file reviews. In fact, the employees shared that the

accreditation process led to other more frequent and new procedures and trainings, as well as increased communication and morale.

Increased communication and morale

According to the quantitative data, most felt that the accreditation process has made the organizational culture and climate somewhat (3 out of 7) or much better (3 out of 7), while one employee felt that it has remained the same. The direct care supervisor shared that undergoing accreditation has increased staff involvement and communication. This has brought more consistency across shifts.

> It did get the staff more involved...So when all of them get together, they would communicate through verbally plus written documents and stuff like that. And so that helped keep a lot of accidents down or communication stay up front so we know we could kind of like relate to what is going on with the children and the staff and office staff.

Before going through accreditation, information about what happened with clients during one shift was not consistently communicated to the staff on other shifts. The case manager said that this increased staff involvement has also increased staff morale and has promoted teamwork.

> **…**maybe the morale…everyone that works here knows that being accredited is better… It helped with the teamwork because during the time that we were going through accreditation, it was stressed as to how we all have to go just fall in and just help out each other.

The direct care supervisor echoed that going through accreditation has increased staff morale and has kept staff focused. As an employee shared on the survey, "It appears that we have better teamwork and committees have been formed to articulate and implement new and better strategies for our client's needs." Another employee wrote, "It's something that's going to keep on going. It will keep you motivated to do better."

Responses to some of the survey questions showed that most employees agreed (4 out of

7) or strongly agreed (2 out of 7) that "The accreditation process enabled the motivation

of staff and encourages team work and collaboration", while one employee indicated that

she was neutral or had no opinion. Further supporting increased communication and

morale, all employees either agreed (5 out of 7) or strongly agreed (2 out of 7) with the

statement that "The accreditation process enabled the development of values shared by all

professionals at this agency."

According to the Executive Director, the agency's governing board also became

more involved during the accreditation process. The Board received training regarding

fundraising procedures and development activities and established a conflict of interest

policy due to COA's governance standards. The COA self-study required that the agency

submit biosketches on each Board member. The Executive Director said that this has

allowed the agency to more actively assess their needs when filling vacant Board

positions.

More frequent trainings and procedures

Some trainings and procedures were required to be conducted more often per

COA. For example, the agency was not conducting fire drills during two of the three

shifts, but COA required them to be conducted on all three shifts. COA did not specify

the accepted evacuation time for the agency so the Executive Director asked the local fire

marshal for advice. During my tour, she pointed out the hooks on the walls for each

child's coat and their shoes were placed under their beds so that they can easily perform

evacuations with minimal time. Per the agency's first PQI goal, the direct care supervisor

shared more about the fire drills.

> We do fire drills, but now we are really onto them because we're trying to get our time down…and we're doing them more frequently. We try to do them every time a new child come in, or at least once a month, or every, you know, couple weeks or something like that. Sometimes it might be every week.

Per their second PQI goal, the agency now also conducts staff and client file reviews

every month instead of every six months.

First aid trainings were also required to be conducted more often, per COA. COA

requires them annually, although Red Cross's first aid trainings do not expire for three

years. In order to not incur additional costs, the Executive Director was resourceful

enough to find a volunteer in the community to conduct the trainings who charges the

agency only for what it would cost him to purchase the certification cards.

Another procedure that was affected by the accreditation requirements was about

verification of vehicle insurance and driver's licenses for employees. Typically, insurance

carriers do verifications every year, but the peer reviews cited on the PCR that they

needed to be conducted every six months. The Executive Director called a local senior

center that had a new transportation program to ask about their procedures. She learned

that employees' driver's licenses at least can be verified through the Department of

Motor Vehicles website. To meet COA's requirements, the Executive found resources in

the community.

New trainings and procedures

Some new trainings and procedures were instituted as a by-product of undergoing

the COA accreditation process. For example, a training on blood borne pathogens was

instituted when the first aid trainer, who was familiar with COA, noticed that the agency

needed it to meet COA's requirement. When the client medication logs were examined

for the self-study, it was noticed that not all staff understood various measurements, such

as cc and mL. The Executive Director found a retired nurse to volunteer to provide

training on measuring and dispensing medications. This then led to additional training by

a mental health/psychiatric nurse regarding psychiatric medications. The Executive

Director and direct care supervisor both said that the binder from the training with

information on various medications has been very helpful and useful for the staff.

Reviewing procedures during the self-study also led to more detailed client intake

and assessment. The agency now uses various forms to document client information,

including their medications and behavioral issues at intake. As the Executive Director

shared,

> That has been a wonderful change because it has given us a lot of information
> immediately. Where as before we were calling the case workers after the kids had
> gotten in here and that is when we might find out that we have children in here
> who were supposed to be on medication and nobody brought it, even though they
> were asked the question when the initial phone call comes in…Then sometimes
> they will walk in the door and they will have what we call like a little pharmacy
> of medication you are bringing with this one child and you did not tell us that.

The direct care supervisor said that this additional information has helped them better

address children's needs. This is also reflected in surveys. All the employees responded

that they agree (6 out of 7) or strongly agree (1 out of 7) with statement that "The

accreditation process enabled this agency to better respond to the population's needs."

In addition, privacy concerns are also now more formally addressed during client

intake. "We now have a form for the case worker and the child if the child is old enough

to sign giving us permission to release information from them." These recommendations

made by the peer reviewers on the PCR helped to formalize the intake and assessment process as well as gather much needed, important information about the children as they enter the agency's care.

The Accreditation Decision

A few months after my visit, I spoke with the Executive Director and found out that the agency had been notified by COA a few weeks prior of their successful accreditation. She spoke about how the news has given her new energy and her commitment to continue what they have begun. They are planning on having a party to celebrate this achievement with the staff but are still waiting for the COA plaque that will make it feel all the more official. She will display the COA logo on their website, invite the local newspaper for press coverage, and let potential funders know of their new accreditation status.

Agency #03

A classic playground and swing set occupies the front of the house and blooming, bright hot pink azalea accent the lawn. This is one of three homes that agency #03 has for group living services. They have the capacity to serve up to 13 children from birth to age 21 who are under the care of the state. Until 35 years ago, children in this county were actually kept in jail when a proper home for them could not be immediately found. The agency was founded in the 1970s when citizens peacefully protested and raised funds to start an emergency shelter. A second home, which is located in a residential area about a mile away from the original home, was added in the late 1980s. The third and newest

home was just completed about a year ago with funds from private donations, grants, and a state's housing financing agency. There was a need for more emergency shelter as children were being placed out of county and the agency turned away more than 40 children in 2005-06 because they were filled to capacity.

The Executive Director has been leading the accreditation efforts at agency #03 since they applied nearly three years ago. It is a small agency with 15 employees and the majority are direct care staff. An administrative assistant position was created and filled a few months prior to my visit to focus on bookkeeping and she now also works on data entry for Performance and Quality Improvement (PQI) activities. In addition, a program director position was created and filled about a month prior to my visit. The new director was hired because of her experience with accreditation and quality improvement. In addition to in-depth interviews with the Executive Director, administrative assistant, and program director, I conducted a focus group with five direct care staff. Since agency #03 was small, the surveys were left for the employee, along with a stamped and labeled envelope to return the completed surveys directly to me. Nine of the 15 employees completed the OSC measure and eight of those nine also responded to the COA accreditation survey. Two OSC surveys were excluded in the analysis due to missing data from 11 or more items (10%).

The OSC data revealed that agency #03 had an above average level of proficiency, and highly rigid and resistant organizational culture (Figure 5.5). The organizational climate had an average level of engagement and was very low in functionality and highly stressful (Figure 5.6). The morale was shown to be near mean (Table 5.2). Agency #03's organizational social context may be related to their experience with the COA process

being lengthened by accreditation decision deferrals from COA and the changes that they made to initiate a PQI system. For example, the high rigidity and resistance, high level of stress, and low functionality could reflect that the agency had just begun to gain employee buy-in for the new PQI system. With near average levels of proficiency, engagement, and morale, agency #03 is in the midst of responding to their second deferral from COA and determined to become accredited.

Figure 5.5 Agency #03 Culture Profile   Figure 5.6 Agency #03 Climate Profile
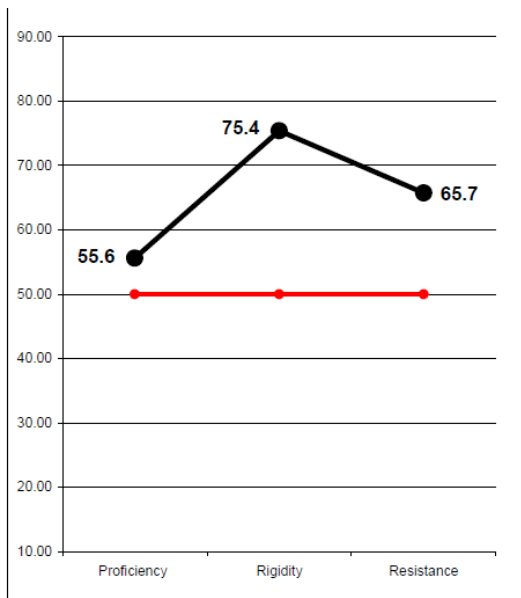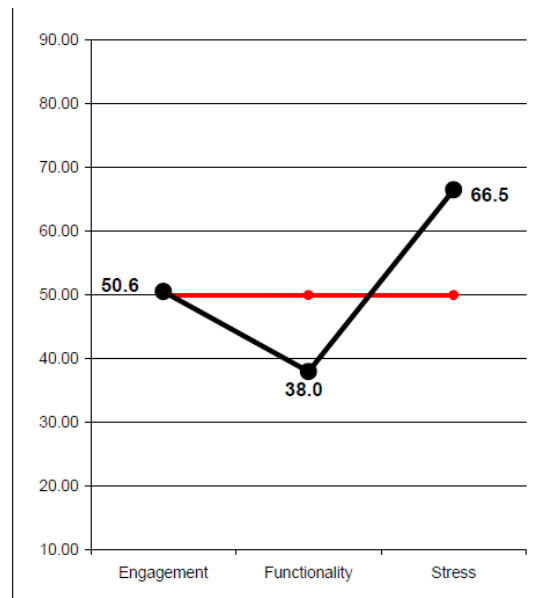
Despite it being a particularly very busy time at the agency, the employees were generous and open about my spending the day there. The Executive Director thanked me and said that she considered it an honor that I had included her agency in my study. The privilege was truly mine.

Motivations for Pursuing COA Accreditation

It was the Executive Director's decision to pursue accreditation at agency #03.

She became the Executive Director in 1992 and first learned about accreditation through

her involvement in the state association of children's agencies. She decided on COA as

their accreditor because she said that it was the most recognized. She had also considered

the Commission on Accreditation of Rehabilitation Facilities (CARF) and Educational

Assessment Guidelines Leading towards Excellence (EAGLE) accreditation, but she

visited some local COA accredited agencies and was pleased with what she learned. At

one COA accredited agency, she was told that perhaps they should try an "easier

accreditor" but the Executive Director decided to become accredited with COA because

"easier doesn't mean best". The program director added that COA was the best fit since

the Joint Commission uses a medical model and CARF is more about rehabilitation.

Various internal and external factors led to the decision to seek accreditation.

To make needed changes: "You're going to have some sort of internal check and
measures…not throwing kids out there higgilty piggilty…"

According to the Executive Director, "The main reason that I felt that

accreditation was what we needed was because of the framework and the background, the

policies and procedures…We needed something that had a good formal process to it."

She sought to use the accreditation process to make changes that she saw were necessary

for the agency to grow and evolve. The program director added that accreditation will

help the agency "keep up with industry best practices." She also echoed the Executive

Director's point of view.

You're going to have some sort of internal checks and measures to make sure that your business is doing what it is intended to do and you're not throwing kids out there all higgilty piggilty, and not bothering to check up to see that you're actually accomplishing anything. I think that's probably the strongest reason.

Requiring accreditation "...to delineate good providers..."

The trend in agency #03's state has been towards requiring accreditation. In fact, one of the primary reasons why the Executive Director decided to seek accreditation was because, a few years ago, the state's association of children's agencies made accreditation a requirement for membership. She shared that the association needed a way to distinguish agencies that deliver quality services because there was growth in the number of children's agencies as well as an increase in incidents and even child deaths.

> ...so the association and the members decided that there needed to be a way to delineate good providers and those who were really in the business to do the work for children and families as opposed to those who were in to making a quick buck and be gone, that accreditation was the way that we could meter that.

Furthermore, the employees that I interviewed said that it looks as though the state may follow suit and make accreditation of children's homes mandatory. Thus, this pursuit of accreditation was due to and in anticipation of changes regarding accreditation requirements. Staff also very briefly mentioned that being accredited may qualify the agency for more funding opportunities.

To gain recognition: "...it was deserved to make them stand out..."

Another motivation for seeking accreditation was to gain recognition and to signal their distinction to the community. For agency #03, accreditation was sought to bring them validation.

> ...it was just the recognition that I felt that, after thirty five years of caring for children the way that they had, that it was more or less, it was deserved to make them stand out and also say to the community or anyone else that we were serious about what we did.

The Executive Director felt that the agency deserves the validation and recognition that accreditation could provide them for their years of service to the community.

Experience with the COA Accreditation Process

COA accreditation at agency #03 has been a long process that started almost three years before my visit. The Executive Director first looked into COA accreditation in 2005 and officially applied a year later. After being granted a six month extension from the original self-study deadline, they submitted the self-study in the fall of 2007. It was especially challenging for the Executive Director to balance the accreditation process along with her other responsibilities, especially when staff turnover required her to work as direct care staff at times. The survey data showed that, while three employees indicated that they were involved in the self-study process on some level (1=somewhat involved, 1=involved, 1=extremely involved out of 8), most employees were not at all involved (3 out of 8) or not aware (2 out of 8) of the self-study. This reflects that the Executive Director shouldered much of the work.

Their site visit was in early 2008 and the Executive Director said that it went well. She described a positive experience with the two peer reviewers during their three day visit. She made sure that the staff understood the purpose of the site visit and tried to ease their anxiety.

117

> …the staff said, well, "What do you want us to say?" and I said, "Just say the truth. Just say who we are, because," I said "If we're anything other than who we are every day, they'll know." We had a wonderful site visit.

One of the staff members shared that she remembered meeting with one of the peer reviewers and had a positive experience. The staff member particularly appreciated being able to share honestly with the peer reviewer and said, "Nobody really asks us stuff like that, like what we would change and what we feel would be more beneficial for this place." Most of the employees (6 out of 8) responded on the surveys that the site visit was not at all burdensome.

A month after the site visit, the agency received COA's Pre-Commission Report (PCR). On the surveys, half of the employees (4 out of 8) indicated that responding to the PCR was not at all burdensome, but one employee indicated that it was burdensome and another employee indicated that it was extremely burdensome. The agency responded to the PCR a few months later, and a few weeks after response, COA's Accreditation Commission deferred their decision and requested additional information from the agency. The agency then paid COA to receive technical assistance from them. After the agency submitted their response to the deferral, they received news in the fall of 2008 that the Accreditation Commission deferred their decision once again.

When I visited, the agency was working on responding to the second set of deferral requests made by the Accreditation Commission, which is due in a few weeks following my visit. The Executive Director expressed some frustration about this process.

> … it was frustrating in feeling like, okay, we've done this, but now it's a different thing that we're being told to do. And in the small agency like we were, it was just kind of hard to meet that and still have an understanding of, okay, how is this really going to help the child?

Understanding and responding to the standards

The Executive Director said the biggest challenge of the self-study was gaining clarification on COA's standards. She explained that throughout the COA process, the agency had a few different Accreditation Coordinators and they each had different interpretations of COA's standards. The Executive Director thought that it should be more consistent.

> … if you start out with one reviewer, it should be a situation where the standards and what's expected is real clear and the perceptions are not based on that individual but based on what the standard is supposed to convey, or say.

She added that, "I've never been a quitter. I may give out, but not up and if they come back with another deferral, I'll say, "Okay, who changed their mind this time and give me a good reason."

With some guidance from an outside consultant that she hired, the Executive Director compiled all of the documentation and wrote the self-study narratives. She also commented that she spent a lot of time questioning how best to respond to COA's standards. The program director shared that communication with COA was lacking and that the agency did not know who or how to ask questions regarding the standards.

> I think that they [COA] try to be available, but if it's not built in from the ground up, it doesn't permeate the entire mission of the agency, then it doesn't really work, and I don't think that's really the way that they're set up to offer that kind of support. I think that they're really good at creating a structure and a set of guidelines for the way they want things to come out on the back end of things, but in terms of guidance through the process, it doesn't sound like it was necessarily a positive experience all the way through for this particular agency.

The program director felt that COA is not designed to be able to support agency-wide implementation of the accreditation process and standards; that is up to the agency. She also thought that the standards could have been more specific at times.

I think that they [COA] have a tendency to go really broad with their standards and to have sort of one particular thing that will be like a big catchall, whereas if they broke it down with more specificity, it would be much easier for especially for a small agency, like we are, to sort of figure out exactly what they're looking for…

Recommendations for PQI to PIC

COA's main concern was regarding the agency's Performance Quality Improvement (PQI) plan. Responding to these recommendations was a major challenge and has contributed to the long accreditation process at this agency. The Executive Director shared that the consultant they hired at the start of the process recommended a top-down approach to PQI, but this did not gain much buy-in from the staff. As the staff shared, new forms and policy and procedures manuals were handed to them from the administration as a part of PQI but "it was never really explained fully." Staff expressed that they felt that they could not ask questions because they would "get chewed out." If they made any mistakes, the forms were returned, marked in red. As one staff member exclaimed, it "felt like you were in school!"

A couple of months before my visit, PQI had changed since the new program director was hired to revamp the system. The program director said agency had the wrong approach to PQI.

> …the agency had a really fundamental misunderstanding of the purpose of the PQI system…their approach to quality was to just measure everything in sight and try to sort of pull something useful out of it after the fact. So it was really just kind of backwards kitchen sink, shotgun kind of approach to quality. And the staff were really sort of disenfranchised and upset with the process because they have all this paperwork and they really don't know what it's being used for and it's burdensome on the management…

The program director is currently focused on responding to COA's Accreditation

Commission's concerns regarding PQI with a completely new PQI model. Even the name

was changed to Performance Improvement Cycle (PIC) system in an effort to increase

buy-in.

> When you would sit and talk to staff or even to the leadership and somebody
> would say "PQI" they would like kind of cringe and hunker down in their seats
> and everything, they hated just the thought of it, because it had been so much
> work and so little good had come out of it previously.

Reviewing the new PIC Plan showed how the program director began PIC goals with the

mission statement. She then interviewed staff to identify the agency's core values and

then translated them into goals, "And after that was in place and I gave everybody a

chance to give feedback about using, what sort of indicators they wanted." This was in

contrast to the top-down approach and was gaining more buy-in from the staff.

Perceptions of the Impact of the COA Accreditation Process

Most of the employees who responded to the surveys at agency #03 thought that

the COA accreditation process improved services on some level (2=somewhat improved

care, 3=improved care, 1=improved care a lot, 2=missing). As one of the employees

wrote on the survey, "It has enabled the agency to take a close look at what measure,

tools, policies, etc. are important to meet the standards required. By doing so, it has

helped the agency more toward delivering quality care and stressing accountability."

Another employee commented on the survey about the benefits of the accreditation

process.

> The process has forced the agency to approach business and services in a totally
> different way; assessing best practices and modernizing in a way that would likely

not have happened otherwise. I think it also will have a long term effect on the way staff view themselves and their contributions to our success.

When asked regarding evidence-based practices, the program director said that their state is currently discussing evidence-based practices and undergoing the COA process can prepare the agency for changes ahead.

> …going through the accreditation process and putting systems in place and having a strong business model and things like that will grant you the ability to absorb the impact of those changes, if you do decide to go with evidence-based practice.

The surveys indicated that half of the employees felt that the agency's culture, climate, and work attitudes had remained the same (4 out of 8), while the other half felt that it is somewhat better (4 out of 8) due to the accreditation process. Most of the perceived impact of accreditation stemmed from the agency's evolution of quality improvement at the agency.

PQI: Additional documentation and data

The direct care staff expressed frustration that the initial PQI plan was only vaguely explained to them and they were asked to fill out additional paperwork. Most of the forms were for tracking expenses and clients' activities. Staff described the paperwork as "stressful" and that "it felt like life or death" because it felt as though their job could be in jeopardy if they made a mistake.

Several employees mentioned that tracking children's progress in school led to more children being identified for needing tutoring, but one staff said, "I felt like we were so caught up in numbers, numbers, numbers, budget, budget, budgeting, that the educational part of it wasn't as important. " Another staff also recalled that this stressed

out one of their clients because she started to understand that their tutoring was being

tracked and so she did not want to attend tutoring as often, but her grades did improve.

Staff also said that the additional paperwork led to less time with the children.

> Well, I think all the kids know about the extra paperwork, you know, and because you say, "Well, okay, you know, I go to do paperwork, guys, leave me alone for a little while I've got to do some paperwork."

The administrative assistant added that the nature of the data collected for PQI is

changing since the new program director implemented PIC.

> "…the emphasis now is changing it so it seems more useable, like the data seems more useable. You know, for example, it doesn't maybe have as much to do with budget anymore, as it does with how the budget fits into the actual running of the agency and that sort of thing. I believe, earlier when, perhaps before all the PQI stuff really mattered as much, they're all the things the board wanted to keep track of, like how much we're spending on food, how much we're spending on activities. But I believe that's going to change now because of the accreditation process and the focus on just broader measures, I think.

PIC: Additional staff and staff involvement

The Executive Director said that going through the self-study helped her and the

Board realize that she needed more staff support, thus the administrative assistant and

program director positions were newly created as a result of undergoing COA. In fact,

staff shared that the new staff "may have us more open-minded about this COA thing."

As the program director expressed,

> I feel like I'm parachuting in the middle of a war zone here to a certain degree, so it's a difficult thing to sort of dive into midstream, but it's definitely worth doing. I have an interesting vantage point as an outsider coming in for the first time and being sort of trapped between two worlds, you have this other sort of business model that existed before for the agency, which was very, very sort of loose and you have this new sort of world that they're stepping into and it's an exciting place to be. And a lot of that is attributable to the accreditation process. There is very much a growing up that's going on here, you know?

123

As PQI evolved into the new PIC system under the direction of the new program director, staff were more involved in the quality improvement process. Their feedback was incorporated into the PIC goals. The administrative assistant also said that the direct care staff "feel like they have more of a say in all this" and "they're more hopeful" about the new PIC system. These changes were spurred by the feedback from COA's peer reviewers, thus undergoing COA accreditation led to this evolution in the agency's approach to quality improvement.

Evolution of the agency: "...to reexamine and have your business grow up..."

According to the responses on the surveys, most of the employees agreed (5 out of 8) or strongly agreed (1 out of 8) with the statement that "The accreditation process is a valuable tool to implement changes" but one employee indicated that they strongly disagreed with the statement while another was neutral or had no opinion. According to the program director, undergoing COA accreditation has helped the agency evolve since they are a small agency that has functioned as a "homegrown business."

> A lot of what any accrediting body does is sort of force you to reexamine and have your business grow up, you know? If you're doing sort of things in a homegrown kind of way, you have to change to get with best practices and with proper documentation, and have a real business model, and I don't know that necessarily anyone here had done that stuff before, and if you haven't seen it, you don't really know what you should be doing, what to model it off of, you know?

Part of the evolution and growth of the agency has been the additional documentation for policies and procedures. The Executive Director added that this has been difficult for staff in addition to their day to day responsibilities, especially at this small agency.

> ...it's not that we weren't doing the things, it's just the documentation, the pure documentation of what we do every day, and sometimes it is difficult if you're the

only one on duty and you're doing different things and you have a lot of different things happen, you know?

The program director also said that documentation has clarified expectations for staff. For example, due to recommendations from COA's peer reviewers regarding consistent client file reviews, she has instituted a new form.

> It's been done, but they didn't have a form that was actually consistent, so they were just kind of going in and leafing through it and making notes on what they saw and that sort of thing, and what they want to see is consistency. That's one of the things that accreditation is really good for; it's forcing you to be consistent in the way that you approach your business, rather than reinvent the wheel every single time that a task comes up. You are going to have to have a system in place to address that need every single time.

The program director continued to describe how this has already made a difference.

> I think that people crave this. I mean, we talk, and all the staff understand the way it affects the kids, but the staff need it as well, the management needs it, you know, the executive director needs it. Structure is a helpful thing. If you have a structure to work within, things feel less chaotic, and so, uh, even just sort of seeing the way that things are going to go with the performance and quality system, with the PIC, people feel relieved. So even something as simple as having a form to use when you're doing client file reviews and things like that, is extremely helpful, just because people know what their expectations are.

The COA accreditation process at agency #03 has given them the opportunity to put structures and process in place, to grow and evolve.

The Accreditation Decision

A few months after my visit, I received an email from the agency's Executive Director informing me that they had become COA accredited. They received a phone call from their COA Accreditation Coordinator with the good news. The Executive Director wrote, "We are so excited, now we just have to maintain it!!!!" The long accreditation

process for the agency had ended in successful accreditation and they already have an eye towards reaccreditation.

Agency #04

I spent a day at agency #04's main administrative headquarters where several of their employee office spaces occupy a 10 floor downtown office building. Their space also includes a room decorated with Character Counts posters and other encouraging messages that is used for group therapy with youth in the juvenile court. This small to midsize agency was established several years ago and currently has approximately 60 employees. They provide counseling, support, education services and family preservation services. On any given day, they have approximately 600 open cases.

The past two years at this young agency have been particularly full of growth; the agency began to provide remedial/in-home family counseling services, won a competitive state contract for child welfare services which required accreditation, opened several new office locations, and successfully completed the COA process. The Clinical Director was responsible for writing the application for the state's request for proposal and also led the accreditation efforts at this agency. This led the agency to apply for COA accreditation in the fall of 2007. Less than a year later, they submitted their self-study. The site visit followed a few months later and the agency received and also responded to the Pre-Commission Report (PCR) within the next month. The agency then received news of successfully achieving COA accreditation within the same month. A plaque from COA making the accreditation official is proudly mounted on the wall in the lobby area.

I interviewed several key informants at the agency about COA, including the

Clinical Director, the Executive Director, Intake Coordinator, Performance Improvement

Coordinator, and Office Manager. I was welcomed warmly by those in the office that

day. Since the agency has several locations a few hours away and most services are

delivered in clients' home, supervisors and administrators spend a lot of time on the

telephone and many regularly travel to their other locations. Thus I was not able to

conduct any focus groups. Additional offices located hours away and employees' home-

visiting may have also contributed to the low survey data response rate. The agency

liaison offered to distribute the surveys that I packaged in stamped and labeled envelopes

so that they could be returned directly to me. Since only two employees returned the

surveys, they were not included in this analysis. Quantitative data could have shown a

broader view of accreditation at the agency, supplementing the qualitative data from the

interviews. In addition, the quantitative data could have provided an organizational social

context profile of the agency. Everyone is extremely busy but accreditation was made a

priority, and as the Clinical Director said, "We were going to be accredited…failure was

not an option."

Motivations for Pursuing Accreditation

Agency #04 became accredited several months before my visit because

accreditation was a requirement for maintaining a state contract to provide mandated

child welfare services. The agency also provides remedial mental health services for

voluntary clients. If they did not become accredited, the agency would have lost the

contract, and as the Executive Director shared, this would have caused the agency to lose

50 to 70 percent of their business, which could have made it difficult for them to remain in operation.

The Clinical Director emphasized that the state contract was the only reason the agency pursued accreditation; she did not think accreditation would improve the agency since they were already meeting high standards.

> Well, we felt, as we looked at the service requirements for accreditation, we felt that we were going to be in good shape, because we have always tried to maintain high standards. The state comes in, because we do a lot of business with the state, they come in and they do audits at least once a year, where they seek to recoup money and they do that by reading files or looking for things that aren't quite right. And, if there's anything that's not quite right, you have to pay that money back. We have never had to pay back to the state. And, so, there wasn't the issue of, 'well we want to get COA accredited because we feel like it will make us a better agency.'…we feel like we're already kind of there.

Accreditation requirement: "…the contract basically pushed us into making our decision."

There were over 200 agencies throughout the state serving children and families and the Department of Human Services decided to streamline services through a competitive bidding process. DHS divided the state into several regions and issued a request for proposals (RPF) to select agencies to serve the regions. Agency #04 successfully attained one of the contracts with the state to be one of the several agencies, but since the agency was not accredited at the time the contract was awarded, they were required to become accredited within two years. The Executive Director also shared that

> We had thought about it for quite a while, because we knew other agencies that had gone through the process, but we didn't know enough about it to be convinced that it was something that would really benefit us. Because it's quite pricey and it's quite time consuming. And so it was one of those things that the contract basically pushed us into making our decision.

Choosing COA: "COA accreditation just matched so much better."

The state contract gave the agency a choice of national accreditors, including

Joint Commission, Commission on Accreditation of Rehabilitation Facilities, in addition

to Council on Accreditation. The Clinical Director shared that they considered the other

accreditors before deciding on COA.

> Well, originally, we were looking at achieving accreditation through CARF, and, because our original bid proposal for the RFP, we felt matched up better with CARF, and the process, we thought, would probably be a little easier. Well, after they awarded the contracts to the agencies, the state changed the contract…CARF was much more oriented to the business or the office practices whereas, COA is much more outcomes based and that was, the state put in that in the stipulations…there's a list of like ten things that you have to accomplish or you don't get paid. And so the COA accreditation just matched so much better.

The Executive Director also shared that the agency considered Joint Commission

accreditation, but it focuses on hospitals, while COA uses a social service model and

"just fit the services that we do better." She added that she felt that "COA has kind of

become the standard for our industry" as she has noticed that many other children and

family service agencies in their state also chose COA as their accreditor. She also had

some prior experience with COA and was more familiar with it.

> But for the most part, my partner and I had both been through the COA process on a periphery level with other agencies that we had worked for. So we kind of had a somewhat a working knowledge of the process and so we were more comfortable with that.

Reacting to the accreditation requirement: "…unless you're forced to do it, why do it?"

The Executive Director candidly expressed her thoughts about the state requiring

accreditation for contracted services. She questioned the cost of accreditation, as well as

the need for additional oversight.

I was not happy. Nobody was happy. Because, number one, it was going to cost us ten to twelve thousand dollars to get it. The other thing was we're kind of an independent lot here. We don't feel like we need an oversight agency like that telling us how we should run our business, what's good business practice, what's not, and that kind of thing.

The Clinical Director also pointed out that, "because the cost of accreditation is so high, unless you're forced to do it, why do it?"

The Executive Director commented that oversight from accreditation did not offer any relief from oversight from the state. In other words, the state still does not offer deemed status.

So, it's like we're going to have all this oversight, which by and large, COA standards are higher than the state standards, but yet, now we have to go out and get all this accreditation, spend all this money, and you are still going to come in and nitpick me, from the state side of it. It's like, you know what? If you want us to do all this, then stay out of it and let these guys monitor us. So, it's like a double whammy. You want us to do all this stuff, but why? You're going to keep checking on it anyway. So, it was just kind of an irritant in that sense.

Experience with the COA Accreditation Process

As one of the agency administrators described, "…I think the process is good. It's intense and it needs to be intense. I don't think you want, I don't think anybody wants some flighty agency providing not so good mental health services to families and children." The Clinical Director bore the most all of the responsibilities through the accreditation process, including the self-study, preparing for and organizing the site visit, and responding to the Pre-Commission Report (PCR).

From a broader perspective, the Executive Director expressed some of her opinions regarding their experience with COA during the process. She mentioned that more communication with COA at the start of the process would have been helpful.

…the one thing I would say that they need to do, to enhance the experience is really send somebody out face-to-face from the get go…it's kind of like an education. You want to sit there with your instructor face-to-face before they go, "Okay, now the second half of the semester here, you had all your stuff, go finish it up and bring it back at the end of the semester and we'll see where you land."

She also said she would have liked more regular contact with COA throughout the

process.

To me, and maybe I'm just needy, I don't know, but it seems to me, again, for the money that you're paying, I shouldn't have a monthly phone call. I should probably have a weekly phone call, even if it's just to touch base…

The Executive Director further described the agency's relationship with COA, which,

from her perspective, may help explain their communication, of lack thereof, with COA.

…I had talked to some people that were very familiar, had been reaccredited multiple times, and they said to me, they gave me some advice, they said, "When you go into this, you need, they need to look at you as you're the customer. You're not; you do not have to kowtow to them. They're there for you." And I really didn't get that sense, and we really kind of almost had to push that issue. But, see, ultimately, they know that they want your money, but they don't need you. They don't care about me, honestly, as a customer. Let's face it. They're a large, national organization. Other than the finances, they could care less if I'm one of their customers or not. That's just a business relationship. I'm not criticizing them for that. I think fundamentally probably somewhere underneath it all, they want to help people do better to help other people.

The self-study: "It was pretty much the bulk of a year of my work…"

The Clinical Director said that it was a natural progression for her to lead the

accreditation efforts since she wrote the RFP application which required accreditation. To

prepare, she attended COA's accreditation training and said that it helped her

tremendously. The Clinical Director wrote the agency's self-study with some input from

staff and discussed that this was preferable.

…it's recommended that you have a committee for each different section and then you have one person that pulls it all together. I've talked to a lot of different people that have done that and it's a nightmare, because you have everybody's different opinions, and you'll have different sections of the agency with different rules and policies and procedures for the same standard, even though it's applied in different areas of the agency…it very confusing for people and I think that's one of the reasons why some people have had rejections, because it's not consistent, whereas, because I was the only one who basically did it, everything was pretty much consistent from beginning to end.

The Clinical Director said that the self-study "was pretty much the bulk of a year of my work…I mean I was probably working twelve to sixteen hours a day, seven days a week." This meant that she often worked from home. She shared that the biggest challenge was something that was completely outside of anyone's control; a natural disaster struck and destroyed the Clinical Director's home, along with the self-study draft that she had brought home. Fortunately, she had a lot of the materials on her office computer. She retrieved the self-study binder from the debris and recreated some of the other materials. COA and the state both offered them an extension, but the agency was able to meet original deadlines.

The site visit

When the agency felt unprepared for the site visit, the agency asked COA to postpone it. COA's response was that they felt the agency was prepared enough and that there would be a financial penalty for rescheduling the site visit. The Executive Director expressed

> So, what that told me was, they weren't concerned with me, they were concerned with their agency and how that was going to affect them if they had to reschedule their reviewers. So that was very clear to me, even in the very end that this is just a big business to them.

The site visit was conducted as originally scheduled and the key informants shared various responses regarding the site visit. Two peer reviewers from COA spent two and a half days at the agency. To prepare for their visit, the Clinical Director organized a mock site visit with a peer reviewer from another local agency. She described the site visit experience:

> It was kind of fun… We take great pride in what we do and to go through the process of identify, this is what we do and, you know, to have our self-study accepted right away and have somebody to come in and actually look at what it is we do, it was, you know, we felt pretty good about it. And the interviews went very well, and it was, it was pretty interesting. It was nice to have some feedback and, so it really wasn't bad.

The Intake Coordinator also described that it was nerve-racking, but they felt that peer reviewers were genuinely there to help the agency improve and it was not nearly as bad as they expected. One agency administrator shared that it was a positive learning experience and she felt that they could have a partnership with COA, sharing ideas regarding how to achieve client and agency outcomes.

While the Executive Director appreciated the peer reviewers' genuine, helpful attitude, she expressed some concern about the depth of their review.

> What they did was they came in with their personal interest areas and focused on two or three areas. And, as a business, that doesn't really help me, because I'll be perfectly honest with you, we knew going out of that, we know going into this site review, there were some areas we were going, "Ohhhh, we're not good." And we didn't have good stuff lined up, so it's like, "I don't want them even asking me about that, because I know it's not going to turn out good." So, again, it's like trying to get past the test, but in reality, the test didn't help you because they didn't ask you things that you're not good at. So, it doesn't help me as a business if I know I'm shaky in an area and somebody doesn't challenge me on how do I shore up that shaky area.

The Executive Director understood COA's limitations while she mentioned that one of

the peer reviewers was a veteran but the other was a new reviewer who could have used

an additional reviewer mentoring her through the process.

Pre-Commission Report and successful accreditation

Document review revealed that the agency received only two recommendations

on their Pre-Commission Report (PCR) from COA. The recommendations were

regarding documentation of facility (fire extinguisher checks, tornado and fire drills) and

vehicle maintenance checks. The reviewers found that the agency was implementing all

of the other standards with the vast majority of them receiving the highest rating. The

Executive Director actually thought a list of recommendations would have been helpful

and was surprised that COA did not have more recommendations. She reiterated her

feeling that the review was not very thorough.

> We got a couple of things, but I know there was more than that. So, I just get the
> sense that somebody didn't look through it real thoroughly. Cause if they did,
> they would see that we didn't address some things very attentively.

The Clinical Director easily responded to COA's recommendations and the

agency received news of their achieving accreditation a few weeks later. The Intake

Coordinator described what the accomplishing accreditation meant.

> We were all pretty happy when that plaque showed up and we were able to put it
> on the wall. It's something little, but something we worked hard for and
> something we want to continue to work on and maintain. So, it does make me
> proud to be able to say that, yes, we did do that and we are there and we've
> accomplished it.

The Clinical Director commented positively about the accreditation experience but mentioned that its cost is prohibitive and questioned what the agency gained.

> I think it's a great process. I've worked with other agencies and I think that every agency should be accredited. With that, I would say the predominant reason why other agencies are not is cost…What did we get for that money? We got a nice plaque.

The impact of accreditation at agency #04 was not seen as significant because many felt that they were already providing high quality services. As the Clinical Director expressed, "Our standards for quality of service I don't think were affected because the standards were already there. If anything, I think our standards and expectations for service are probably higher than COA's." The Clinical Director also said that accreditation has not significantly affected the employees' work at their agency.

> I guess you have to look at it as they go into people's homes on a daily basis. They're dealing with crisis; they're dealing with a lot of different issues. Whether or not we're accredited really doesn't impact what they do or how they do it, or certainly it does not affect what they get paid. It really has very little impact on them.

She added that "…because the changes that occurred were over a period of time and really they saw it more as the changes as a result of the contract, as opposed to accreditation." Since the other agencies in their region also had to become accredited, accreditation has not affected their referrals.

While the Executive Director thought the peer review could have been more thorough, she also felt that the internal review that accreditation initiates was beneficial.

> The process showed us that gaps that we had. It really showed us, I think, in a lot of ways where we are. We already see your strengths, but you don't always recognize your gaps and they really help us recognize that.

She also added that accreditation keeps them "vigilant… and not let things kind of how they slide to the back burner if they're not a crisis." One of the agency administrators felt that accreditation is "that foundation of the drive of good practice, of best practice…" Along the lines of best practices, I inquired about the impact of COA on evidence-based practices at the agency. She responded by sharing that the agency staff are trained in cognitive behavioral therapy, such as Truthought's corrective thinking treatment model, and Triple P, a positive parent training program. The Clinical Director said that accreditation may impact evidence-based practices "in the future because it's allowed us to build in some mechanisms." She mentioned the client level data that they are collecting to examine "program effectiveness" but said that this was more related to the state contract requirements rather than COA.

According to the Performance Improvement Coordinator, accreditation "…ensures that everybody's going to be on the same page throughout our agency…" This perspective was also reflected in other comments from the Intake Coordinator and the Office Manager, who said, "A lot of the benefits were just being about to work with staff and everybody as a team together with everything on this whole process. It brought a lot of us closer."

Enhanced staff training and supervision

A couple of areas that accreditation has helped enhanced are regarding the agency's staff development through training and supervision. For example, the Clinical Director is responsible for the trainings and she has used COA's standards to plan the

trainings for the next two years. She said that this has reinforced the clinical importance of the trainings.

> …cause before our trainings were more compliance based, "You need to do this documentation and you need to…." It was more management, rather than, "Okay, today we're going to talk about cognitive therapy and how you apply that to working with children." We've done trainings on parenting, on working with suicide, a lot more clinical…

An agency administrator added that the communication and consistency in their trainings have also improved: "…pretty much it's driven us to be more consistent with the message we deliver… the communication is just more enhanced."

One of the administrators also shared that the consistency in staff trainings has also carried into staff supervision: "…it's also brought some real good structure to our group supervisions…ensuring that everybody gets the same message, derived from our administrative meetings…the communication is just more enhanced." In addition, she said that timeframes for submitting paperwork and consequences are now more clearly documented for staff, supporting further consistency. As the Executive Director said,

> …there's a trickle down theory here. It makes us better as an administrative team, and because our administrative team does direct supervision of our direct care staff, there's a very much a trickle down of best practices and administratively to best practices and direct care…I believe our staff are better trained, because that was an emphasis in the early staff training as part of quality, program quality improvements.

Documentation and more consistent policies and procedures

Accreditation has affected the documentation and consistency of several policies and procedures. This is reflected in, for example, the agency's updated personnel files. As the Clinical Director shared,

Our personnel files were not in good shape before COA…And so, before we had one basically, no, it was about one and a half drawers of a small filing cabinet that just had information about personnel. And now we have the whole filing cabinet is full.

She described that this additional documentation and organization made their most recent state audit go very smoothly. Also regarding documentation, the Clinical Director mentioned the agency's finances: "We have an accountant who keeps all of that in line, and here again the process of accreditation wasn't making a lot of changes, it was just about documenting what we have always done." The Executive Director said that accreditation has also influenced them to have regularly scheduled, quarterly, in-person meetings with their accountant.

The Executive Director and the Clinical Director both mentioned that accreditation has increased the agency's consistency regarding HIPAA and client rights policies and procedures. As the Clinical Director shared,

> …one of the nice things about accreditation, in that respect, was that it created a standard that somebody else from outside of the agency basically said, "This is what you have to do."
> And so things like that where they are now standardized throughout the agency, so everybody has informed consent and privacy statements…

The Office Manager described her work for COA accreditation on clarifying and documenting the agency's emergency preparedness procedures, including routing emergency exit plans for tornadoes, floods, bomb threats, as well as emergency procedures for staff when off site. She said that this is particularly important for this agency because most of their staff do a lot of in-home therapy.

> It's just nice to know that when they are away, out in other offices, that they're safe and clients are safe as well. It's just that quality that we can provide to our clients and, again, our staff.

PQI and monitoring agency program goals

Other areas affected by accreditation were regarding PQI and the agency's

programmatic goals. Although not highlighted on the PCR, the Clinical Director shared

that the peer reviewers

provided important feedback regarding their PQI plan.

> The most significant feedback we got probably was pertaining to the use of agency goals and PQI. Many of our objectives and goals were related to client satisfaction or specific client or client files, but we didn't really have any that were related to the agency.

She then continued to give an example of how the agency now collects more information

at intake for remedial services.

> …we changed our referral form. We added what's called a 'severity scale' and on this form, they identify specific behaviors, and then the frequency of the behaviors and then we have a severity scale from one to five that is used to identify what, how severe that behavior is at the time of intake. Every six months this form is repeated, so we are able to develop a gauge, not only individually, but again as a program…

Since the agency has been accredited for several months, the Executive Director shared

that accreditation has influenced their team meetings and consistent monitoring.

> Well, like I said, in our administrative teams, we've now set an agenda that's pretty concrete around those things we need to keep monitoring. Otherwise, before it was kind of like, "Well, we got this month's agenda and then we got next month's agenda and the next month's," and they would hit different things, all-important things, but different things. And this, by us doing this, it keeps all of those things out in front of us on a regular basis, so we're not as hit and miss as we were before.

As the one of the administrators added, COA has infiltrated the agency's PQI and

administrative meetings.

> COA is like in the room; it's always present per se, on how we do policies and procedures and how implement. So, as a team, it's there. We practice it on a monthly basis, whether it's conscious or unconscious.

Agency #05

Established almost 100 years ago as an orphanage, agency #05 has evolved and

has grown to now provide children's residential treatment, outpatient mental health, and

foster care and adoption services. It has a few offices located in neighboring counties

with more than 100 employees. I spent three days at their main administrative offices and

the QI Director, who was my liaison throughout the process, took me on a tour of their

group homes and cottages that are within walking distance in the surrounding quiet

residential neighborhood. She highlighted the newly renovated kitchen and a backyard

area that used to be a pile of dirt and is now a patio area with a basketball court that was

painted by volunteers. She also pointed out beautiful murals painted by a local artist that

decorate a couple of the buildings.

Agency #05 had been accredited by a state association for more than a decade and

they applied for COA accreditation a couple of years ago to seek national accreditation.

They submitted their self-study approximately a year after they applied and the site visit

followed several months later. COA did not have any recommendations for the agency,

so the agency did not have a Pre-Commission Report (PCR) from COA to which to

respond. Instead, COA informed the agency that they had successfully achieved

accreditation. They were accredited by COA for almost a year at the time of my visit. A

plaque attesting their accreditation status hangs in the lobby.

I conducted in-depth interviews with the agency's Executive Director, the Quality

Improvement (QI) Director who coordinated the entire accreditation process, in addition

to one of the QI staff members, the three program directors, and three other

administrators who led a committee to work on responding to certain COA standards. I

also conducted four focus groups, each with direct care staff or social workers from the agency's three programs. One of the focus groups had five employees, another had three, and two groups had two employees.

For the quantitative data, I was able to distribute and collect several of the surveys following the interview or focus groups when time permitted. For the remaining surveys, I worked with the liaison to have them distributed, collected by the liaison, and returned directly to me. Thirty-two (out of 118; 27%) of the employees responded to the survey; 30 out of those 32 completed the survey portion that was developed for this study and 31 completed the OSC. Two surveys were excluded in the analysis due to missing data from 11 or more items (10%).

The OSC data showed that agency #05's organizational culture had an above average level of proficiency and was also highly rigid and resistant (Figure 5.7). Their organizational climate had a low level of engagement, while their level of functionality and stress was above average (Figure 5.8). The agency's morale was shown to be slightly above the mean (Table 5.2). The high level of rigidity, resistance, and stress, along with the below average level of engagement, may have affected some of the employees' frustrated reactions to the extra work required for COA accreditation in addition to their regular responsibilities. In contrast, the agency's high level of proficiency, functionality, and morale that was slightly above average reflected their desire to meet a higher level of standards and a sense of pride from achieving accreditation.

A couple of the employees wanted to confirm how their responses would be kept confidential and that their participation would not affect their accreditation status. I reassured them that their individual responses would not be shared with any of their

141

Figure 5.7 Agency #05 Culture Profile   Figure 5.8 Agency #05 Climate Profile
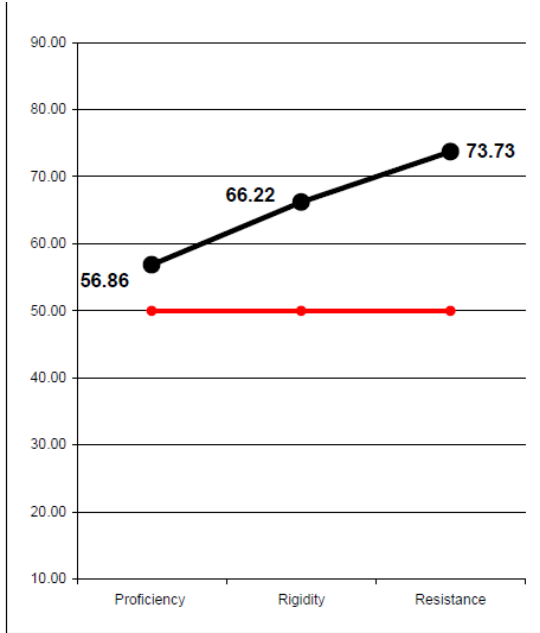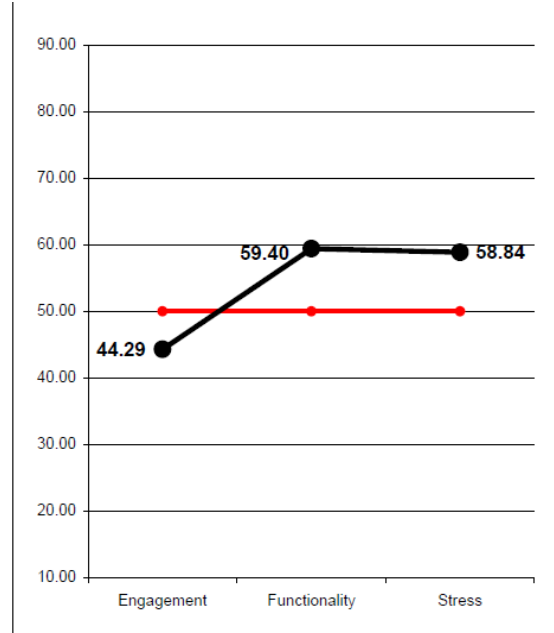
supervisors, that their participation or lack thereof would not affect their employment in any way, and that I was not affiliated with COA. With the reassurance, everyone was receptive and willing to share their thoughts about the agency's motivations to seek COA accreditation, what that experience was like, and how they perceived the impact of COA accreditation.

Motivations to Pursue COA Accreditation

The Executive Director initiated the pursuit of COA accreditation while consulting with the QI Director regarding the decision. As the QI Director described, she was one of the decision makers; it was discussed in management meetings and board meetings and became a "collaborative decision." The decision to pursue accreditation felt different for a couple of employees in a focus group who said, "I think the decision was already made and we were just being told." One of the director's shared that her initial

reaction to the decision to pursue accreditation was that it is "too expensive and a waste

of time" and "we had better things to do" but by the end of the process, she said "…I

think now it's worth it in the sense that you get bragging rights. A lot of the other

agencies that are quality have it, so it's good for us to have it."

The Executive Director also shared that the agency had to prepare itself in order

to be ready to apply for COA accreditation, while weighing the costs and benefits.

> …both financially and programmatically, I think you need to be at a starting
> place…We are a relatively small or medium size non-profit and it costs a good
> deal of money and you don't want that to detract from an individual child's
> treatment. You don't want to have to say, "Okay, let's lay off three therapists and
> get accredited."

This comment speaks to the high cost of accreditation and the potential for its costs to

outweigh the benefits. The primary motivations behind seeking COA accreditation were

the desire to attain national accreditation that would continue to focus on quality of

services. The national accreditor would set higher standards for the agency and bring

more recognition to enhance their reputation.

From state to national accreditation: "It was a moving forward."

Agency #05 was already accredited by a state association that requires their

members to be accredited by the association or by a national accrediting body such as

COA, the Joint Commission, or the Commission on Accreditation of Rehabilitation

Facilities (CARF). Anticipating reaccreditation with the state association, the agency

decided to seek national accreditation instead and made it a part of their strategic plan a

few years ago. The Executive Director said that the state-level accreditation "is good to

have to have but it is not as documented as well as COA and it is not as structured and

consistent as COA." Another director added that, compared to the state association, COA

was "a lot more in-depth and a lot more thorough."

The agency also considered undergoing Joint Commission accreditation but chose

COA because it was more applicable for the agency.

> It seems that COA is more focused on what we do. Either one would have been fine, but I think that they are more applicable to the programs we do. More similar agencies are accredited by COA. Some are accredited by both. We are very much evolved from a group home. I think that some agencies are evolved from hospital or more of a medical setting and I think that COA addressed our perspective of the field a little better…

Seeking national accreditation was seen as a next step for this agency. According to the

Executive Director, it wasn't spurred by any specific problems.

> I think that it is a process of improvement. It wasn't a reaction to anything. It was a moving forward. It was, "How do we move forward and get better along the way?" So it is not like, "Ooh, we really have this problem and this will fix it." It is, "We are doing okay and it is the next step to being even better."

This was echoed by another director at the agency who said that, compared to the state

level accreditor, COA "seem to have a more intense process to go through so it was more

a challenge to try to get that accreditation and a way to just better the agency…"

Improving QI: "We wanted to make sure that we were doing things in a quality way."

The Executive Director said that the primary reason for pursuing COA

accreditation was to ensure processes that would support high quality services.

> We wanted to make sure that we were doing things in a quality way. I think, more in-depth. I think in order to have a quality that is long lasting and ingrained in the culture, you need a system approach, not just quality overall but each individual step in our process…so it's not a matter of each individual being good and hoping for the best from my level but each individual following a process that is studied and agreed upon head of time that will lead to quality.

The QI department had been established for several years at this agency before COA accreditation and they sought to further refine their existing QI efforts. In addition, the lead executive and the one of the directors have worked at other agencies that were undergoing accreditation. According to that director, this prior knowledge and experience may have "pre-disposed" them to COA, meaning that they had learned from going through accreditation and may have unconsciously or consciously implemented things at the agency according to COA's standards. This agency seemed to be ahead of the curve and they wanted to continue to improve.

Higher standards, recognition, and reputation

Stemming from the agency's desire to ensure quality, several of the employees thought that being held to "higher standards" was a motivating factor for seeking COA accreditation and that this would lead to recognition and esteem for the agency. As the QI Director said, "I really do think the motivation was to be considered one of those organizations that is representative of having higher standards, more quality services than the average…" This was also echoed by a couple other employees: "…you are kind of held to higher standard…so you are looked at as a better agency." According to another director, accreditation also "makes us look more responsible, more kind of cutting edge with what's going on in the field." This would also legitimize the agency as another employee stated, "I think it was to have more of a reputable agency, to have more honor and esteem, like a college is accredited, it means something." Another director added how accreditation may benefit the agency's reputation.

We were told that it was just an accreditation like others we had, as far as more steps to build I guess respect for the agency and status because we do rely on other agencies respecting what we do and taking us seriously.

A couple of employees also mentioned that recognition from accreditation was hoped to possibly bring more funding opportunities to the agency. For example, one of the directors shared that, "Some funders, when you apply for a grant or different sort of funding, will ask, 'Are you accredited by any organizations?'" Some other employees mentioned that the agency had hoped that the recognition from accreditation would attract more foster care parents.

Experience with the COA Accreditation Process

The agency's COA accreditation efforts were organized by the QI Director. She remained in contact with COA and oversaw the process. The Executive Director emphasized the QI department's critical role: "I think having a quality improvement department that can really lead the process is very important. And so, with the people we have there now, that really became much easier." The QI Director described how she "broke the agency up into committees…presented to everyone who the committee chairs were going to be and those were assigned to our program directors or specific agency directors…" Throughout the process, the QI Director "would meet with the committee chairs and collect things from them and we would go through all the information and we did that several times…" Several of the agency's directors attended the COA training to learn more about the accreditation process, which they found it to be very helpful. In fact, the QI Director attended a COA training before actually applying for COA in order to "get a feel for it prior to just making the decision."

Direct care staff shared various reactions when recalling the accreditation experience. Some of the direct care staff expressed that accreditation was new for them but were positive about their experience. As one employee stated, "…I didn't know what to expect but I knew that it was going to help the facility." Another employee added similar sentiments, "…it was nice to know that they cared to that level to be accredited." While some employees said that they felt a "sense of pride" about undergoing accreditation, the employees in one of the focus groups candidly expressed their frustration about how the additional work was delegated to them.

> I am not exaggerating. It would be like we would walk in and it would be like, "Okay this has to be done by today, so drop everything you are doing and make sure you go to every single [client] and it needs to be signed and needs to be put in the file today."

These employees' reactions were reflected on the survey as responses to the statement, "The accreditation process enabled this agency to better use its internal resources (e.g. finances, people, time, and equipment)." While many employees agreed (11 out of 30) or strongly agreed (3 out of 30) with the statement, a few employees strongly disagreed (2 out of 30) or disagreed (2 out of 30) and 12 employees indicated that they were neutral or had no opinion.

The self-study

With assistance and guidance from the QI Director, the committee chairs led the writing of the self-study narratives and compiling the required documentation. The quantitative data indicated that most of the employees (9=somewhat involved, 7=involved, 5=extremely involved) were involved in the self-study process. Most of the

employees also thought that COA's standards were reasonable, feasible, and important.

The Executive Director specifically appreciated the flexibility of the standards.

> I think that the process and their rules give you a chance to get it right. It is not like here, here is the right way. They are saying, here is what to measure what is it that you want to do…it really kind of gives you something to measure yourself with.

A few employees felt that having been accredited by the state association did help them with the COA self-study process as they noticed that they had many requirements already in place. One employee expressed validation, "I'm doing something right because this is what COA is saying is supposed to be done and this is what I'm doing so we're actually meeting the needs and services of the residents here."

Several employees shared that the most difficult aspect of the accreditation process was how time consuming it was. They put in many extra hours in order to complete the self-study; staying late, coming in early, rearranging their schedules with clients, working on the weekends, and working from home. Despite the additional work accreditation demanded of employees, together, the agency was able to rise to the challenge in order to meet COA's self-study deadline. The QI Director shared that it was a challenge getting everyone to turn in their materials on time, but she also said,

> I don't think anyone came and said, "I can't get this done." I think that everyone took responsibility for their roles. It certainly meant working some late nights, coming in on a Saturday or two, but we tried to make it fun. I would bring treats. We tried to make it as pleasant as possible."

While 10 out of the 30 employee who responded to the surveys indicated that the self-study was not at all burdensome, 13 employees said that it was burdensome to some extent (7=somewhat burdensome, 3=burdensome, 3=extremely burdensome). Seven employees were not aware of the self-study process.

The site visit

Following the self-study, the agency prepared for the site visit. The QI director coordinated the visit for the two peer reviewers (a third member was not able to attend at the last minute) who spent almost four days at the agency. In preparation, some of the departments did their own internal reviews of their files, used checklists and rated themselves on the standards to find areas for improvement.

Many described the site visit as a very positive experience. One of the directors commented, "I don't want to say easy, but it was a comfortable process." As another director described,

> That was fun. We had a great group of reviewers, very nice, friendly. They were great, actually. They were fun. They weren't stuffy. You always get nervous that you're going to find some stuffy kind of or that's going to come and nitpick at what you guys are doing wrong. These people came and just praised us for everything that we had in place. They were just very cordial to us and they weren't looking to scold us or look down at us for not having certain things. They were here to help us, to make our agency better.

This positive experience was reflected in the survey responses. More than half of the employees (17 out of the 30) indicated that the site visit was not at all burdensome. Several employees (4=somewhat burdensome, 3=burdensome, 1=extremely burdensome) indicated that it was burdensome and five were not aware of the process.

The QI Director particularly appreciated that, "if something came up and they really couldn't find something, then they would ask about it and see if they were missing something…I would prefer that, rather than having to do it later." Several employees expressed that the positive feedback from the peer reviewers was very validating. As one of the directors said,

149

> …So it was kind of cool for an outside people to come in and go "Wow. You know we were really impressed and I really like this and actually I'm going to use this when I go back to my place."

One of the focus groups shared their experiences meeting with the peer reviewers during the site visit. While they appreciated that one of the reviewers asked particularly about staff satisfaction, the reviewer left the door open so it did not feel completely confidential. One of the employees said that she was still honest about her thoughts and opinions but there was no follow-up regarding her concerns after the site visit.

Successful accreditation

Following the peer reviewer's assessment of the agency's self-study and the site visit, they did not have any recommendations for the agency. The agency was told that this was very rare, since most agencies receive a Pre-Commission Report with recommendations to respond to prior to the accreditation decision. At the next COA Accreditation Commission meeting, agency #05 was accredited.

COA rated the agency as a "1", having full implementation/outstanding performance, or a "2", having substantial implementation/strong performance, for all but one standard. According to the Final Accreditation Report that was examined during the document review, only one area was identified for improvement and rated as a "3", partial implementation/concerning performance. The area of concern was regarding the agency's lack of a mechanism to monitor the quality of services provided by independent contractors. In the Final Accreditation Report memorandum, COA states,

> We ask that you address this through the agency's CQI process. Even though this standard did not require correction in order to achieve accreditation, it will be made a part of your file and reviewed during your next accreditation cycle.

The QI Director described that she has been working on maintaining

accreditation, joking about how she "frequents" the COA website to keep up with any

updated standards. She said, "I would rather stay on top of it than have to go through the

entire process again for reaccreditation. So, I really want to stay on top of it." She also

shared that, since they have become accredited, staff have become more interested in

COA.

> Staff will come to me and say, "You know we currently do this, this way, is that because of COA, or can I change it to this way, is there a reason why we do it this way, is it a COA standard and that's why we are doing it this way? So that's interesting to me and that tells me that the staff are thinking about COA.

Some direct care staff and social workers also said that they would also have liked to

have been acknowledged for their additional work during the accreditation process:

> … the only thing that kind of disappointed me throughout the whole [COA] process is that it happened and as a floor staff we stepped up our game tremendously to make it happen, and that was over, and there was no congratulations, there was no… 'this is what happened, this is what we got.' It was like it's over…that's where we kind of feel disconnect with the whole COA thing…

Perceptions of the Impact of COA Accreditation

When asked about the impact of COA during the in-depth interviews, at first,

several employees could not think of how COA had affected the agency. This may reflect

that the agency did not have any recommendations from COA, indicating that they were

already implementing most all of COA's standards. As one of the directors stated,

"…Since those are in place, again, there wasn't a dramatic shift, because they were

standards we had already implemented, so we didn't have to say, 'Now you're going to

start doing this.'" One of the staff members said, "I don't think it impacted our day to day

job at all." The Executive Director added that this response reflects how COA has become a part of the agency's culture.

> … a lot of people won't even know that, okay that came from COA. Or they won't be able to verbalize why they think that way or why do we check with quality improvement or why are they looking at my files. It is now ingrained as a process, not as a list of rules from COA.

As reflected in the survey data, more than half of the employees felt that the agency's culture, climate, and work attitudes have remained about the same (16 out of 30, 53.3%) and while many others felt they were much better (5 out of 30, 16.6%), somewhat better (6 out of 30, 20%), and a few (3 out of 30, 10%) felt they were somewhat worse due to the accreditation process.

When asked if COA had affected the agency's adoption of evidence-based practices (EBPs), one of the directors referred to the agency's examination of client outcomes: "…we did a little before, but we're doing it way more now…to see what's working, what's not…" In comparison, another director and one of the focus groups discussed the county's list of approved evidence-based practices, such as cognitive behavioral therapy. The director shared "…We currently do not practice of any of those…what our Executive Director has requested is that the milieu that we do use, that they try to get that evidence-based because there has been research…" She also mentioned that, although the county has not stated that "they will only pay for evidence-based practice, it's moving in that direction so we're trying to be proactive…" The county seemed to be driving this attention towards EBPs more than COA.

As the employees thought more about the process, some were able to think of how COA has affected the agency. However, employees in one of the focus groups questioned its benefits, given their frustrating experience with the accreditation process.

152

As reflected on the surveys, several employees (6 out of 30) thought that the accreditation did not improve care, while all others thought that accreditation improved care to some extent (9=somewhat improved care, 12=improved care, 3=improved care a lot). One director said that it was difficult to discern the impact of COA on client outcomes due to possible case mix issues.

> … by the nature of the kids we're in-taking right now there's definitely higher mental health challenges. So it makes it hard for me to kind of look at the outcomes because I think well you have to factor in so many different things.

Overall, employees shared that COA accreditation has influenced various areas, including policies and procedures, staff work and caseloads, increased QI monitoring, and stakeholder input.

"… shoring up our policies and procedures": Documenting, streamlining, and developing

Many of the examples of how COA accreditation has affected the agency were about documenting, streamlining, and developing policies and procedures. According to one of the directors, "I think the biggest benefit was shoring up our policies and procedures." She shared an example of how reviewing the agency's HIPAA and privacy policies led to them revise the different versions of the policies to be one consistent policy "in nice layman terms and appropriate for the reading level of our clients."

One of the directors shared that this focus on policies and procedures during COA accreditation helped them further develop a program that was relatively new for the agency.

> …it was actually very helpful, because I didn't know that much about it often, so it helped discern, "oh, these are things we need to do for [our program]"…all

153

kinds of new stuff that we needed to be doing that it helped us get the program in better shape.

Another director emphasized the importance of documenting policies and procedures.

> I think that when staff, at all levels, but particularly newer or mid-management staff, see that things are documented, that they're not just coming from me as some sort of authoritative pronouncement, but they actually see that it's part of the process that everybody is held accountable to, it sort of mitigates, spreads out some of the difficulty in new people learning the task and maintaining the procedure.

This documentation keeps staff accountable and helps when training new staff by maintaining and clarifying expectations.

Formalizing and implementing policies and procedures

Shoring up policies and procedures due to COA accreditation led to formalizing and implementing them more consistently. One of the employees wrote on the survey, "It allowed us to formalize the things we were going. It helped us focus in on certain areas and how we can best implement policies, procedures, etc.?" For example, one of the directors shared that they formalized the procedures for client psychiatric evaluation referrals. The referral forms were revised to document the reason for referral, which then led to "the therapist participating in every single initial psychiatric appointment" and the director said that, as a result, the "treatment was becoming more I think holistic because there was better communication..."

Reviewing policies and procedures also formalized their procedures for staff debriefing after incidents, such as restraints. The agency's special incident reports now include a section for staff to indicate if staff want to debrief about an incident with the trainer.

> I really think the restraint one has really helped. I love getting that report. It gives me a totally different perspective because the lead trainer e-mails it out to everyone and you get a completely different perspective than what the kids have to say about why they were restrained.

The debriefing procedure carried over to client runaway incidents, but one of the staff said that, "Depending on the client, it could be counterproductive to their treatment, in that I am giving them negative attention." Employees shared that client discharge plans also became more thorough as a result of reviewing COA's standards for the self-study. As one of the directors described, the case managers "actually worked with the kids, to do it, because they asked them you know when you're leaving... when you get ready to leave what do you think you're going to need." Although they have always provided aftercare services, this focused their efforts and has made a difference.

> Especially our older kids like our 18 year olds that leave and maybe they go into transitional housing or maybe they go back with relatives. For them to still feel like they have somebody that can help them get what they need because sometimes it's like you know they turn 18 and then go back to their parents, but the parents are still their parents, who couldn't care for them before. So I think it's been good for them to know that "OK. I still need help and I can work with them still." So that's been positive.

Another affect of COA accreditation was learning more about the Indian Child Welfare Act and how that policy could affect services. As one director said, "...every once in a while we have kids where, they can't find someone within the tribe for them to be placed with, so they get placed with us." Another example of formalizing procedures was regarding the agency's consultants and contractors. Their personnel files have been made more uniform and their evaluations have also been enhanced contractors in order to better assess their performance.

More monitoring for QI

At agency #05, COA accreditation helped to both broaden and deepen existing QI monitoring efforts. Various indicators were examined more closely, such as clients' school suspensions, truancies, number of foster care placements, and runaways. Monitoring this information has alerted the QI department of clients' needs. For example, when the QI department notices two suspensions for a client, they arrange for a team decision meeting (TDM) during which school officials and social workers meet to discuss how to intervene. Staff shared that TDMs have led to Individualized Education Plans (IEPs) for some clients, as well as an in-house "training on the history of IEP's and things that they could be discussing, language to use in an IEP meeting in order to be able to get the services needed for the child."

The QI department had been tracking various indicators on a monthly basis but COA accreditation required them to present the data on a quarterly basis. One of directors specifically mentioned that this broader look at indicators was helpful "to come up with solutions to try to figure out if they seem to be increasing, why is it increasing, how can we get them to decrease, or if we are doing really well, what is it that we have implemented that is really working to make sure we keep doing it." For example, examining runaway data on a quarterly basis helped the agency notice seasonal trends. Related to identifying clients' trends, the survey data revealed that many employees agreed (11 out of 30) or strongly agreed (3 out of 30) with the statement, "The accreditation process enabled this agency to better respond to the population's needs." Eleven employees indicated that they were neutral or had no opinion, two disagreed, and

three strongly disagreed. Increased monitoring for QI helped to identify clients' trends and needs.

Stakeholder input

COA accreditation increased input from internal and external stakeholders at agency #05. Several employees discussed the PQI meetings that the QI staff conduct with each department.

> We had planned it before but it didn't happen all the time as consistently and now been accredited through COA we're consistent and we're having these meetings and we're having the meetings with every department.

QI data and trends are discussed at these meetings and staff are also allowed to voice their concerns. The QI department shared that "hearing people from different levels, their director being there, their supervisor, the actual line staff, it's allowed them to build better communication in there." Although the departmental PQI meetings provided staff with a forum, some employees felt that the meetings are "pointless" because "in this culture you cannot talk with the director present or else it's going to come down on you." Another employee expressed that their concerns about job satisfaction were not addressed.

> Well, the other thing is, we did more surveys and these surveys are addressed in the PQI meetings. Anything that pertains to what our children say we are jumped on like we are not doing X, Y and Z, but when it comes to our satisfaction, you say something and instead of her saying "okay, well I will bring it up higher and see what we can do" it's kind of squashed right then and there, like it's a waste of your time to even bring it up.

COA has also influenced the agency's increased focus on external stakeholder input. One of the directors shared that identifying external stakeholders during the COA accreditation process led to Community Partnership meetings with neighborhood residents, police officers, county social workers and representatives, and agency staff.

157

She shared about how the meetings helped when dealing with some negative feedback

from the community.

> ….we held a meeting and it certainly wasn't a positive meeting at that time, to the point where people in the room were saying, "we don't want you here, we want you to move to some place that's not near us", and we had some neighbor complaints…since then, it has become a very positive experience. One of the police officers, the sergeant, has become a board member (laughing), but you know, she's become a board member.

Staff caseloads and workloads

 One of the specific changes that came as a result of COA accreditation was a

reduced client caseload for employees in one of the agency's departments.

> And we were taking on, I think, there were times when I was seeing 26 kids. So I noticed after COA that there is absolutely never a time that you are over 15. Ever.

While caseloads were reduced, employees still felt that COA accreditation was additional

work that detracted from focusing on clients.

> If anything, it made us more stressed out. I mean it made us more like we are so worried about paperwork and files and everything that I think sometimes it was to the detriment of our clients and to our kids, because we were so worried about getting this in and that in, so…it was more about that than about, "Okay what is going with Jane or Sally?"

Employees continued to share that, during the COA accreditation process, the

administration gave them notice that their work week was to be limited to 40 hours.

> In fact, as a result of this we now have these different kinds of timesheets that we have to keep track of our hours because we should be able to get all of our stuff done in 40 hours. It became a deal. Like all our work needs to be done and then we need to do these things but never work more than 40 hours.

This decreased morale among staff and they expressed their frustration. They added that

they "didn't have a choice" since they had to tend to their primary responsibilities and

accreditation was "on top of everything else..." One employee described the burden of the

extra workload.

> And you'd be working on something they asked you to do to look for this and
> then they'd come back five minutes later and you're still on that and they're
> throwing something else at you and you still have the pile of other stuff that
> you're doing. I was just glad when it was over.

As one employee responded on the survey, "There have been no benefits to employees or

to residents, no motivations, no increases, nothing to improve, working conditions, living

conditions, well-being or happiness of anyone." They also said that it may have helped

them through the process if they had a better understanding of how accreditation would

benefit the agency. More information about accreditation may have helped to ease some

of their frustration.

> What are the benefits other than the gold star on the agency?...They just said,
> "Oh, this will be really good" and then they didn't say, "Okay, this is why it will
> be good; this is what will benefit."

Using COA to answer to regulation

Agency #05 used COA accreditation as support when answering to government

regulation. As the Executive Director said, accreditation can help respond to concerns

from the county.

> But I think when we do make mistakes I think you can go back and look at where
> the mistakes are and that makes people feel that you are more accountable, that
> you have a better understanding of your program. So, when the county comes out
> and says "what happened here" we can say exactly what happened and how we
> fixed it.

The Executive Director felt that the increased accountability of being COA accredited

would better prepare the agency. A direct care staff also shared similar sentiments and

said that the agency's accreditation status could help when dealing with licensing authorities.

> I think one other thing too it gave me a little bit more confidence in my position in my role as a supervisor because when you're more of a liaison with the county representatives a lot of time there can be you know snide remarks that well I have a client at this facility that doesn't do that and it just sort of made me feel like you know you can make a comment if you want but hey like if they are COA and we're COA we both have the same standards so there's not too much room to complain…

Using accreditation to answer to regulation was somewhat echoed in the survey data as employees responded to the statement, "The accreditation process enabled this agency to better respond to its partners (other agencies and departments it contracts with)." While most (17 out of 30) were neutral or had no opinion, many other employees agreed (8 out of 30) or strongly agreed (3 out of 30) with the statement, with only one employee disagreeing and another strongly disagreeing.

Another director also shared some thought about the role of government and prefers COA as the regulator, particularly because COA's standards are more stringent than licensing standards.

> And quite frankly, I would rather have it privately, agency-driven, you know, composite, a collective-driven setting these standards than the state or the federal government. Yeah, I would rather we do it ourselves, cause if we don't, they will, and we may not like theirs, and theirs may get so impacted by other federal and state laws that we may lose some of our standards. Our standards now at COA far and away outreach what the minimum expectations are contractually for the state or the federal government. So it goes without saying that setting up our own is a much more stringent way of doing it and that you can monitor yourself, as long as you have your colleagues coming in and participating, you know?

Cross-Case Analysis

This cross-case analysis provides an aggregate perspective on the research questions and further supports hypotheses generation. To maintain the situationality of each case while also moving towards a general understanding of the accreditation phenomenon, the cases were compared and some findings across cases were merged (Stake, 2006). Relevant findings were focused around each research aim regarding motivations to pursue accreditation, the experience with the process, and the perceptions about its impact.

Each individual case was reread and codes were revisited to identify findings. Findings were listed for each case and then sorted according to similarity and findings that were contradictory were considered together since they were on the same topic (Stake, 2006). After studying the contents of the sorted findings and referring back to the cases for additional evidence, they were identified and named as a merged finding or as a special finding if they didn't merge (Stake, 2006). Tables with abbreviated descriptions of the findings were created to organize the cross-case analysis (Appendix F). Next, the findings were further examined to highlight those that are most important in order to begin to elevate themes and develop assertions about the accreditation phenomenon (Stake, 2006). Survey data from four of the agencies (survey data from agency #04 was excluded due to low response rate) were also compared across cases to triangulate the qualitative data.

Motivations to Pursue COA Accreditation

The agencies had various reasons for pursuing accreditation and they shared why they chose COA as their accreditor. Across all five cases, certain findings regarding motivations to seek accreditation were noticeably prominent as they were reiterated by several employees. Other findings may not have been as widespread but were still particularly significant in supporting an explanatory model of accreditation. These prominent and significant findings emerged as overarching themes. Most agencies were influenced by external factors, such as policies that require accreditation, agencies wanting to assert their position in the field, and the need to increase funding opportunities. Other factors were internal, related to the evolution and growth of the agency to improve services.

Choosing COA

The agencies shared how they chose COA as their accreditor. They all had a choice in their accrediting body, including the Joint Commission, CARF, EAGLE, and a state association. Most agencies felt that COA fit best for them and was more applicable for their programs. In addition, agency #04 had considered CARF but found that COA was more in line with the requirements of their state contract since it focused more on client outcomes. The two smaller agencies (#02, #03) both sought out primary information from other agencies in their community. They found that other agencies were satisfied with COA and that COA was the most recognized accreditor. The leaders at the larger agencies (#01, #05) had previous knowledge and experience with accreditation to help guide their decision to choose COA.

Accreditation requirements

Policies required three of the five agencies (#03, #04, #05) to attain accreditation. At agency #03 and #05, the state association of child serving agencies required accreditation for membership. Although agency #05 did not foresee the state requiring accreditation, agency #03 thought that it may soon become the case in their state. For agency #04, accreditation was a requirement to provide services under a state contract, which was the primary source of their clientele. Thus, achieving accreditation was a matter of survival for agency #03 and agency #04.

Agency's position in the field

Agencies viewed accreditation as a way of asserting their position in the field. Some agencies (#01, #02, #03) felt that accreditation would help ensure that they are in line with other agencies in the field by spurring needed changes and helping the agency grow and evolve. At the same time, the agencies felt that accreditation would also bring them recognition and prestige, helping them to stand out among other agencies. Agency #04 asserted its position by attaining the state contract, which in turn required them to become accredited. Having previously been accredited by the state association, agency #05 thought that meeting COA's higher standards would further their reputation.

Funding opportunities

The possibility of more funding opportunities motivated most agencies to pursue accreditation. Some agencies (#01, #02, #05) specifically mentioned that funders ask about their accreditation status and that some require accreditation as a qualifier for

funding. Direct care staff at agency #04 mentioned the possibility of funding

opportunities due to accreditation though this did not seem to be as emphasized as it was

at other agencies. Though funding opportunities were not their primary motivator for

accreditation, agency #04 would have lost the majority of their business if they did not

become accredited because they would have lost the state contract.

Evolution of the agency and agency leadership

The pursuit of accreditation was related to each agency's particular stage of

evolution. For agency #01 and #02, the evolution involved new leadership using

accreditation as a means for change. While agency #01 has been established for over 200

years, the new Executive Director felt that it was time for professionalizing. Some staff

also felt that accreditation would help make their service delivery more consistent.

Similarly, the new Executive Director at agency #02 wanted to formalize services and

staff thought accreditation would also increase accountability at the agency. At agency

#03, the accreditation process was viewed as a way to make changes that were needed for

the agency to grow and evolve. Employees expressed that the agency needed a stronger

framework for its policies and procedures, an internal checks and measures system to

ensure best practices. The Executive Director was not new to agency #03, but

accreditation led them to hire additional employees who were a part of the agency's

evolution and helped establish a PQI system.

Experience with the COA Accreditation Process

The COA accreditation experience varied for the agencies, including how the work was delegated and the length of the process. The agencies also discussed the financial cost of COA's accreditation fees, as well as the costs in staff resources and time. At the two larger agencies (#01, #05) the QI Directors oversaw and coordinated the accreditation efforts and asked the program directors to lead the work on certain standards via committees with their staff. Instead of using committees, the smaller agencies relied on one person. At the two smallest agencies (#02, #03), the Executive Directors shouldered most of the work. At another small agency (#04), it was the Clinical Director who led the accreditation efforts and the work. Three of the agencies (#02, #04, #05) attended trainings hosted by COA but this did not determine their approach to the accreditation process.

The time it took for the agencies to complete the COA accreditation process ranged from one year to almost three years. For some agencies, the self-study was the most time consuming part of the process as they described their experience communicating with COA and responding to COA's standards. All agencies described a very positive site visit experience. While two of the agencies found responding to the peer reviewers' recommendations and the Accreditation Commission's deferrals to be a lengthy, challenging process, it was a short and simple process for the other three agencies.

The organizational social context profiles of four of the agencies (#01, #02, #03, and #05) did not reveal any clear patterns regarding how organizational culture, climate, or work attitudes may affect an agency's experience with COA accreditation. The four

agencies had very highly resistant and rigid cultures. The resistance seems almost contrary since the pursuit of accreditation demonstrates their openness to new ways of providing services. The high rigidity could reflect the additional requirements due to undergoing accreditation but this study did not collect data prior to the agencies' pursuit of accreditation. Although not uniformly high, all four agencies were more proficient than average. This could help explain how the agencies used accreditation as a learning tool to improve services.

Regarding organizational climate, the level of engagement at the two smaller agencies (#02 and #03) was near average, but the two larger agencies (#01 and #04) had levels below average. The four agencies all varied widely in their level of functionality, ranging from the 10th to the 99th percentile. Although many employees at the four agencies described their heavy workloads, agency #02 had a below average level of stress while the other agencies all had higher than average level of stress.

Work attitudes showed that all agencies had near or above average level of morale. This corresponded with what employees revealed in the interviews except at agency #05 where one of the focus group discussed how undergoing accreditation decreased their morale. Pre and post accreditation data from the OSC could have revealed more regarding how COA accreditation interacts with organizational culture, climate and work attitudes.

The self-study

At the small agencies (#02 and #03), the self-study placed a substantial burden on one employee who made accreditation their main job responsibility throughout the

process. The responsibility was more widespread at the larger agencies. Either way, many of the employees devoted extra hours, worked on the weekends and from home in order to complete the self-study. In addition to being time consuming, the self-study was referred to as the most difficult part of the accreditation process. During the interviews and focus groups, employees described the challenge of balancing the self-study on top of their already demanding schedules and tasks. On the surveys, the employees were split. While 28.58% to 45% of the employees who responded to the surveys across four of the agencies found the self-study to be burdensome on some level, 33.33% to 71.43% did not think it was burdensome at all.

Regarding COA's standards, some agencies appreciated their contextual nature, while others felt that more specificity would have been helpful. In fact, when contacting COA for clarification on some standards, agency #03 found it confusing to receive different interpretations from different accreditation coordinators. In comparison, some agencies found that COA's standards were validating and that their current practices were already in line with them due to state requirements or the state association's accreditation standards. Two agencies (#03, #04) shared that they would have liked more consistent contact from COA, while other agencies described that their COA accreditation coordinator was very available to them. Those with more experience and knowledge about accreditation seemed more comfortable using the standards during the self-study process.

The site visit

Compared to the self-study, the site visit was seen as the easier part of the COA process. In fact, survey data showed that the majority of employees at the agencies, ranging from 56.67% to 90.23%, felt that the site visit was not at all burdensome. Prior to the visit, most employees were anxious and worried that the peer reviewers would be critical, but the employees found that it was a pleasant experience, some even describing it as "fun". They said that the reviewers were genuinely there to help improve their agency. Direct care staff at two agencies (#03, #05) also appreciated being heard by the peer reviewers, although one group of direct care staff at agency #05 felt that it could have been more confidential since the door was left open during their meeting.

While the agencies enjoyed the site visit process, a couple of employees at agency #01 said that the visit did not seem to be in-depth and that it did not confirm their self-study. This may reflect that the length of the site visit did not always correspond to the size of the agency. Two peer reviewers from COA conducted the site visit for two and a half days at agency #01, but two reviewers spent the approximately the same amount of time at the smaller agencies (agency #02, #03, #04) and spent more than twice the time at another agency of similar size (agency #05). This could be because COA bases the cost of the site visit on a two-day visit. Depending on the size of the organization and number of programs eligible for COA accreditation, there are additional charges for each additional day and additional reviewer.

Recommendations from COA

The nature and number of recommendations from COA following the site visit varied among the agencies. According to the survey data, most of the employees at the four agencies, ranging from 46.67% to 90.23%, did not find it burdensome to respond to COA's recommendations on the Pre-Commission Report (PCR). Most of the recommendations were regarding PQI, reflecting the development of quality improvement efforts at the agencies. While agency #01's PCR asked for more evidence of the PQI activities, such as meeting minutes, agency #02 did not pass the PQI standards and had one deferral from COA's Accreditation Commission, and agency #03 also did not pass PQI and had two deferrals. While the deferrals lengthened the accreditation process, they also helped to create and revamp their PQI systems. In contrast, agency #04 had only two recommendations on the PCR regarding facility and vehicle maintenance checks and agency #05 did not receive any recommendations.

Perceptions of the Impact of COA

The survey data revealed that the majority of the employees, ranging from 77.42% to 100% felt that the COA accreditation process improved services to some extent. With varied eagerness, the employees shared during interviews and focus groups about their perceptions of how the COA accreditation process affected their agency.

Cross-case findings regarding the impact of COA were organized according to Donabedian's conceptualization of quality as structural, process, outcomes indicators. Related to structural factors, COA affected the environment of care, resources, and organizational capacity. Increased organizational capacity significantly influenced

staffing and workload issues at two agencies (#03, #05). Across all cases, most changes were related to process indicators of quality that affected the course or content of care, with PQI standards having the largest overall impact. A couple of those processes influenced some key outcomes, including client discharge outcomes and educational outcomes. When asked regarding the affect of accreditation on the adoption of evidence-based practices, some employees referred to their agency's data on client outcomes while others discussed their agency's use of certain therapeutic modalities. The impact of COA on quality indicators was direct via requirements set in COA's standards or indirect through by-products of undergoing the accreditation process.

Structure

The COA accreditation process affected some structural indicators of quality. According to the survey data, 45.17% to 85.72% of the employees at four agencies agreed or strongly agreed that the accreditation process enabled their agency to better use its internal resources, such as finances, people, time, and equipment.

Although not highlighted upfront during the interviews and focus groups, the COA accreditation process indirectly but significantly affected organizational capacity at two of the agencies. At agency #03, the governing board realized the need to create two critical new positions; the administrative assistant for the Executive Director and the program director, who was instrumental in developing their quality improvement system. At agency #05, some direct care staff attributed their reduced and limited caseloads to meeting requirements in COA's standards.

170

Other COA standards were related to the environment of care and resources and required some simple changes. For example, COA's Administrative Service Environment standards required a couple agencies (#02, #04) to put certain arrangements in place to improve their emergency procedures and to ensure vehicle safety inspections. Related to agency resources, two of the agencies (#02, #04) shared that COA's standards on Financial Management helped them examine their resources more closely. At agency #02, upon recommendations from COA's peer reviewers, they found a volunteer to work on development efforts, and at agency #04, meetings with their financial consultant became more consistent.

Process

Undergoing COA accreditation was primarily influential on process indicators of quality, mostly stemming from COA's PQI standards. Several other COA standards influenced how policies and procedures were reexamined, documented, formalized, and implemented. In addition, increased communication at the agencies was a by-product of COA.

No matter where they were in their development of quality improvement efforts, the impact of COA's PQI standards was prominent at all five agencies. COA accreditation required agency #02 and #03 to institute PQI plans for the very first time. With recommendations from the peer reviewers, changes spurred by PQI ranged from simply improving fire drills, to enhancing file review and data collection procedures, and increasing staff involvement. In comparison, agency #01, #04, and #05 had existing QI systems. COA's PQI standards helped them make their QI meetings and documentation

of the meetings more consistent and increased stakeholder involvement, both within and outside of the agency. A new client outcome monitoring system was established at agency #01. At agency #04, programmatic PQI goals were formulated as recommended by the peer reviewers. At agency #05, PQI standards increased their monitoring of client outcomes, which in turn improved how the agency intervened when concerning trends were revealed in the data.

Additional COA standards affected processes regarding agency staff. Many employees highlighted that COA's standards made staff supervision more accountable and trainings more uniform. Employees shared that this in turn clarified expectations and made services more consistent. While more frequent first aid trainings at agency #02 were compliance based, their training on psychotropic medications, and cognitive behavioral therapy training at agency #04 focused on improving staff competence with clients. At two of the agencies (#01, #05), COA's Behavior Support Management standards drew attention to procedures regarding client restraints, asking for more information about the restraints and instituting restraint debriefings for the involved staff. Employees shared that this helped staff and therapists in treatment planning for clients.

Other effects of the accreditation process on process indicators of quality developed and clarified agencies' policies and procedures. At agency #02 and #04, reviewing COA's standards led them to attain more information regarding their clients at intake, allowing them to better meet clients' needs. On the other end of services, COA's Group Living standards at agency #01 and Outpatient Mental Health standards at agency #05 made their aftercare procedures more comprehensive, thus better meeting clients' needs upon discharge. A substantial change highlighted at agency #01 was instituting an

appeals process to give clients recourse after discharge based on COA's Client Rights standards. COA's Client's Rights standards also made procedures regarding privacy and Health Insurance Portability and Accountability Act more consistent and easier to understand for clients at agencies #02, #04, and #05.

An overall indirect impact of COA on process indicators of quality was increased communication, which led to more teamwork and increased morale. According to the survey data, 37.50% to 85.71% of the employees across four cases agreed or strongly agreed that the accreditation process motivated staff and encouraged teamwork and collaboration, but some also were neutral or had no opinion (14.29% to 50%), while others (none to 19.35%) disagreed or strongly disagreed. At agency #05, one of the focus groups felt that COA decreased morale due to the increased workload during the accreditation process; the employees were frustrated because they did not see the benefits of accreditation. Some employees at agency #01 were also skeptical about the impact of COA.

Outcomes

Across all five cases, most of the employees struggled to think of how the COA accreditation process affected outcomes at first, but they were able to think of a few examples when probed. The survey showed that 25% to 100% of the employees at four agencies agreed or strongly agreed that the accreditation process enabled their agency to better respond to the population's needs, while others (none to 75%) were neutral or had no opinion and none to 16.67% disagreed or strongly disagreed.

Some of the process indicators of quality led to outcomes. At agency #01, the newly instituted appeals process that arose from COA's Client's Rights standards changed some negative client discharge outcomes into positive ones when some clients were readmitted. In addition, their new client outcome monitoring system revealed that more clients were meeting their goals. Two of the agencies saw PQI procedures help to address the educational needs of clients. At agency #03, PQI data identified clients' need for tutoring and improved clients' academic performance. At agency #05, PQI helped to identify clients for special education services and also intervened to decrease school truancies.

COA accreditation may influence client outcomes in time. An employee at agency #04 mentioned that, due to COA accreditation, there is more focus on outcomes during staff supervision though no specific examples of how client outcomes have been affected were given. A few employees at agency #01 and #05 said that the accreditation process had not yet affected client outcomes, though they expressed that they hope that COA accreditation will make a difference for their clients.

Summary of Findings

Each source of data in this study provided a rich description of the complexities of COA accreditation from the agencies' perspectives. Regarding motivations to pursue accreditation, agencies discussed various external and internal factors that led their decision, including policies recognizing accreditation, funding opportunities, and agencies' wanting to professionalize and gain distinction. Each agency's experience varied as they recalled the costs and benefits of the COA process. The self-study was the

most time consuming component and, depending on the size of the agency, one person shouldered most of the work or one person oversaw committees that worked on certain standards. The agencies' length of the process also varied depending on the recommendations from COA, mostly regarding PQI standards. Regarding the employees' perceptions of the impact of accreditation, process indicators such as PQI had the largest impact. COA also affected structural indicators such as staffing and workloads and improved client discharge and educational outcomes at some agencies.

CHAPTER SIX: DISCUSSION

Despite the growing and widespread use of accreditation in the social service and mental health fields, this mixed methods multiple case study is one of the first to examine issues related to agencies' motivations to pursue accreditation, their experiences with accreditation and to accumulate perceptions of agency employees on the impact of accreditation. It explored these issues with five children's mental health agencies that had recently undergone or were undergoing their initial COA accreditation. As presented in the individual case studies and the cross case analysis, spending time at each agency, speaking with the employees, reviewing documents they submitted to and received from COA, and gathering survey data revealed several findings that merit further discussion.

The most significant findings were related to 1) tensions regarding the reasons for seeking accreditation, which could affect its appeal and value, 2) how the costs and benefits of accreditation varied for the agencies as related to their accreditation experience, and 3) perceptions about using COA as a means to an end to improve outcomes. Since there is little pre-existing literature on the motivations, experience, and impact of accreditation, I will not always be able to place these key findings into an existing knowledge context. The chapter will conclude with the study's limitations and implications for COA and other accreditors, agencies, policy, theory development, and further research.

Motivations: The Appeal and Value of Accreditation

Agencies in this study had a combination of internal and external factors that motivated their decision to seek accreditation. While many employees mentioned that they sought accreditation in order to be in line with other agencies in the field, they also mentioned that they sought accreditation to distinguish themselves as one of the best among other agencies. This reflects tension regarding the motivations behind accreditation and also raises the issue of the future trend of accreditation in the field. As accreditation's popularity increases, its ability to signal distinction may decrease. What is the appeal and value of accreditation if the majority of agencies become accredited? How can accreditation remain a mark of quality and excellence? COA accreditation may become more similar to accreditation in education and health care where accreditation is more commonly required. In which case, an agency advertising accreditation as a mark of distinction may actually signal quality problems instead of high quality; touting accreditation status may play on consumers' ignorance if not being accredited is the exception.

Most of the agencies sought COA accreditation due to policies that required them to achieve accreditation or in anticipation of such policies. This seems to be a trend in the field. As accreditation becomes more commonplace, it could increasingly become necessary for agencies' survival. Many funders have also made it their policy to require accreditation to be eligible for funds.

All of the agencies in the study also had a choice in accreditors and they shared that COA fit better with their programs. COA is the only accreditor that was originally established for child serving organizations. The Joint Commission, in comparison, was

177

originally founded to accredit hospitals (perhaps reflected in their standards for Surveillance, Prevention, and Control of Infection for behavioral health organizations) and CARF was established to accredit rehabilitation facilities. For the other accreditors, the emphasis is on the site visit, as organizations are not required to submit self-studies for Joint Commission or CARF accreditation. The site visit reviewers for the Joint Commission and CARF are compensated while COA relies on volunteers. Agencies #02 and #03 also shared that COA was more recognized in the field and agency #04 said that COA's standards were more in line with their state contract requirements. These reasons may reflect agencies' strategy to maximize the utility and signaling ability of accreditation at minimal cost.

In addition to external influences, internal forces also motivated agencies towards accreditation. At three of the agencies, the leadership decided to pursue accreditation at least partially to justify and urge changes that they saw were needed. Perhaps sometimes an agency needs the extra impetus from an outside force, but the internal motivation for accreditation shows a genuine intent to improve services. If agencies are not seeking accreditation merely for funding or status, these positive motives could continue to encourage the agency to sustain accreditation in between accreditation cycles. This reflects that agencies view COA as having a crucial role in their transformation and evolution.

Experience: Costs and Benefits of Accreditation

Agencies' experiences with COA showed that some were burdened more than others by the accreditation process and some benefited more than others from it. Some of

the costs were financial, and additional costs stemmed from using staff resources and time. All agencies mentioned the financial expense as determined by COA's sliding scale that is based on each agency's revenue. The cost of staff time and resources was greater at the two smaller agencies since so few employees were able to work on COA. In addition, the COA process was longer at those agencies because they needed to respond to recommendations when COA deferred their accreditation decision. The Executive Directors led their efforts and also did most of the work instead of assigning it to their already overburdened small number of employees. COA's requirements could place more burden on smaller agencies since they have fewer resources.

Not only was accreditation new at these agencies, but the required emphasis on PQI was also new. PQI requires agencies to institute an organizational-wide PQI program to support achieving performance targets, program goals, client satisfaction, and positive client outcomes. This could involve many changes throughout the agency. In fact, according to COA, agencies struggle with the PQI standards the most and PQI was one of the main reasons for the deferrals at two of the agencies in this study. Some employees found it frustrating that they would respond to recommendations from the PCR and COA would return with different recommendations that were not in the initial PCR. This could be because the Accreditation Commission, not the peer reviewers who prepared the PCR, makes the accreditation decisions as COA "incorporates multiple levels of review and the collective exercise of professional judgment" (COA, 2007a).

There was some ambivalence regarding the costs and benefits of the accreditation experience. Employees saw the benefits of undergoing the COA process but also described the burden of the extra work and sometimes expressed frustration. In fact, the

demands of multiple regulators such as accreditators and licensing authorities could actually hinder quality (Brennan & Berwick, 1996). The opportunity and financial costs of accreditation, especially for small agencies, could have resulted in decreased quality of service, at least while the self-study was being written, as employees may not have been able to focus on their regular service delivery and administration. Considering the additional work involved in achieving accreditation, many employees expressed that they would have appreciated more recognition and celebration for the accomplishment from their agency leadership.

Perceptions: Accreditation as a Means to an End

Most of the employees did not or were not able to explicitly share examples of how the COA accreditation process had affected clients. Some were able to produce examples after being probed, but whether or not client outcomes improved was not always upfront. The employees stated various reasons for this, including the difficulty discerning the impact of COA as the severity of their client population has changed, the impact of accreditation on client outcomes could take more time to manifest, and some felt COA lost sight of the clients.

Some of the employees at the larger agencies shared that the impact of accreditation depends mostly on what the agency makes of it; services and client outcomes may improve if the agency uses accreditation as a tool toward those ends instead of as a list of minimal standards to check off every few years. It is up to agencies if they make passing changes just to satisfy the accreditation requirements for reviewers or if they maintain accreditation when COA is not looking. In this way, accreditation

status does not guarantee high quality services or improved outcomes, reflecting COA's philosophy that, "Accreditation is not an end but a means to an end."

Many employees thought that the main direct impact of the accreditation process was how COA's standards required agencies to reexamine, document, formalize, and implement policies and procedures. While COA does not and is not able to require certain outcomes, COA helps put infrastructures for various processes in place that have the potential to affect outcomes. The connection between processes and outcomes are not always clear or robust. Many processes were related to PQI but the sheer number of standards, ironically, could hinder quality by emphasizing many requirements instead of focused quality improvement. Issues regarding fire drill requirements, for example, are easy to identify and easy to resolve but they are not likely to meaningfully improve quality of care for clients. In comparison, increased monitoring of data on clients, such as school performance, could help improve outcomes.

Many employees felt that, indirectly, undergoing accreditation increased morale and teamwork, but there were some staff who felt the opposite; they were frustrated and unconvinced about the impact of accreditation. The OSC data did not reveal any patterns regarding if certain organizational characteristics are related to a more positive or negative accreditation experience. For example, agencies with high level of stress, rigidity, and resistance on the OSC all had morale near the mean, while qualitative data revealed increased morale due to the accreditation experience. COA has the potential to rally employees together or it could overburden them and add to their stress level; perhaps accreditation does both. At the larger agencies, employees' experience with

181

accreditation could have varied by department since each it was up to each department how they organized and distributed the workload.

Limitations

This exploratory study has several limitations. The nature of case study research, even when multiple case studies are used, limits generalizability. Although the response rate for the surveys was high at the two smaller agencies, the response was low at the other larger agencies. In fact, quantitative data from one agency had to be excluded due to the low response rate. In addition, OSC data were collected at one time point and thus did not capture change from before and after the accreditation process. This study also did not examine pre- and post-accreditation outcomes to objectively inform the employees' perceptions of the impact of accreditation. Despite the limitations of the quantitative data, the qualitative data was predominant in this study. There may have been some selection bias related to who was interviewed and who was not interviewed at the five agencies since the agency liaison was relied on for selecting those employees. Although there was the potential for the liaison to include only employees who may have positive views of accreditation, knowing the positions of the employees that participated in the interviews and focus groups revealed that no one was purposefully excluded. Several focus groups were conducted but they were smaller than the ideal six to eight participants recommended when dealing with complex, noncommercial topics with knowledgeable participants (Krueger & Casey, 2000). It is hoped that the richness of the data from multiple sources has helped to counterbalance any selection biases.

Implications for COA and Other Accreditors

The findings revealed some implications for COA regarding each phase of the accreditation process. Other accreditors may also find the results informative if they conduct themselves in ways similar to COA. I comment on six implications.

During the self-study, the agencies mentioned that they could have benefited from more regular communication with COA. Some agencies shared that their COA Accreditation Coordinator was very available and others specifically mentioned that it would have been helpful to have more consistent contact from their Accreditation Coordinator. While COA "encourages organizations to communicate with and make appropriate COA representatives aware of any concerns as they arise" (COA, 2007a), perhaps the Accreditation Coordinators could reach out and contact agencies monthly to check on their progress. One of the agencies in this study had applied for COA years ago but never even submitted a self-study, thus they reapplied for initial accreditation. Perhaps more contact with COA could help keep agencies engaged in the accreditation process. As one employee mentioned, given the high financial cost of COA accreditation, COA could make efforts to remain in contact with their agencies.

More information regarding COA and how it can make a difference for clients could increase employee buy-in. COA could develop materials to distribute to agency employees that share about the benefits of COA and how to use and maximize accreditation's potential. This could help motivate employees and gain their commitment to the accreditation process.

Some other findings were regarding the COA standards. While most found them to be straightforward and relevant, some others mentioned that the standards would have

been easier to understand and respond to if they were more specific and less redundant. COA may want to subject its standards to assessment of clarity to ensure that each iteration does not include any unclear standards or any that do not reflect quality services. If COA's standards can be even more streamlined with an increased focus on key standards that are based on evidence, the burden of accreditation could be decreased and its positive effect on quality of care increased.

Regarding the site visit, all five of the agencies reported positive experiences. While a couple of employees felt that the site visit could have been more in-depth, overall, the employees shared that it was very helpful and that they enjoyed the process. This reflects that COA's strong selection and training process for its peer reviewers. Though a couple of employees questioned the peer reviewers' abilities, COA has been able to produce many reviewers who genuinely assisted agencies to improve services.

While the final phase of responding to COA's recommendations varied for the agencies, it was mentioned that recommendations by COA should be made in one report instead of new recommendations by Accreditation Commission being made after the agency's submission to peer reviewers' PCR, unless the responses by the agencies were not adequate. Though this reflects COA's multiple levels of review by the peer reviews and the Accreditation Commission, the peer reviewers could perhaps aim to make the PCR as comprehensive as possible.

Following successful accreditation, sharing more information with the public about accredited agencies could make accreditation more meaningful. For example, the Joint Commission now provides quality reports on their accredited organizations on their website. The reports include information on the organizations accreditation status, what

services were accredited, when their last survey was conducted, if the organization is implementing national patient safety goals, and any awards the organization has been granted for excellent quality care. COA could provide some similar information for the public, such as accredited agencies' overall ratings on each core standard and information regarding maintenance of accreditation reports. In addition, the accreditation ratings could be used to establish levels of distinction for agencies; those with the highest marks receiving such distinction. This could motivate agencies to go above and beyond the accreditation status to receive distinction and help consumers compare agencies when making their choice for a provider.

Implications for Agencies

Findings from this study also pointed to implications for agencies undergoing or considering COA accreditation. To the extent that other accreditors are similar, these implications may apply to agencies seeking accreditation from CARF or the Joint Commission as well. Four findings are highlighted.

The cost of accreditation, including the time and resources necessary to undergo the process, seemed to be higher at the smaller agencies. One individual at the smaller agencies shouldered most of the work for accreditation. While there was a point person for the accreditation efforts at the larger agencies as they managed more standards since they provided more services, there were more employees available to work on accreditation. All agencies, particularly smaller agencies, need to be prepared for the burden of accreditation and plan for the additional work required.

Agencies undergoing COA could involve employees from the very beginning of the process and inform them of the work that is ahead while providing support throughout the process. The QI Director at one of the agencies shared that she brought snacks for employees when working on the weekends and said that she would think of others ways to get staff excited about the process come time for reaccreditation: "…giving out treats and goodies, having little contests. I think that, that will make people happier." She recalled that the COA training also emphasized this "cheerleading" aspect of the process. Though it may cost agencies additional time and resources, efforts to engage staff during accreditation could pay off.

Employees also expressed that they would have been more receptive to the COA process if they understood how the additional work will make a contribution towards improving services. Many employees did not know a lot about COA accreditation. Those leading accreditation efforts at agencies could spend some time providing employees with more information to help them understand its purpose and its benefits. As mentioned above, COA could develop these materials. This could have increased employee buy-in and could have helped to motivate them through the accreditation process.

Upon achieving accreditation, agencies should spend some time celebrating the accomplishment with their employees, recognizing the additional work done by the employees, and place the accreditation in some meaningful context for the employees. The congratulatory letter from COA's President/CEO is accompanied by a draft memo and can be distributed to all employees. It states

> COA's commitment to maintaining the highest level of standards and quality
> improvement is designed to identify providers that have set high performance
> standards for themselves and have made a commitment to their constituents to

deliver the highest quality services. COA is proud to recognize your agency as one of these outstanding providers.

Employees can be reminded that accreditation is an ongoing commitment and that its benefits could become more evident over time. An all staff meeting could be held to celebrate and the Executive Director could also write a note of appreciation to the directors or others who played keys roles during the accreditation process. These celebrations and communications will increase morale, letting employees know that their hard work has paid off. Motivating and thanking employees can help maintain accreditation and make the reaccreditation process as smooth as possible.

Implications for Policy

Many policies on the local, state, and federal level recognize accreditation. COA markets and works with government entities to gain tangible value for accreditation status, such as mandated accreditation, deemed status (accreditation in lieu of state licensure), regulatory relief (fewer inspections for licensure), increased funding or reimbursement rates for accredited organizations. Although these policies create powerful incentives for agencies to become accredited, we know little about their overall impact on the field.

An Executive Director at one of the agencies specifically made a case for deemed status, since the state was requiring COA and she felt that COA's standards went above licensing, making licensing superfluous. Deemed status underscores that COA's accreditation standards need to be indeed above and beyond licensing requirements and focused on quality instead of a checklist. In addition, while using accreditation as a third party guarantor could increase efficiency and allow for more in-depth inspections of

agencies, it could also lead to oversight gaps. To help protect against such oversight

problems, policies should ensure that licensing authorities continue to receive

information about accredited facilities from the accreditor. For example, it would be

important for licensing authorities to know if there was a change in accreditation status

for an agency.

Should states encourage accreditation? Should states offer deemed status? This

study does not directly answer these larger policy questions, but it sets a foundation for

future studies that could begin to better inform such policy decisions. Agencies and the

government need to be able to fully reap the benefits of accreditation in order to enhance

quality.

Implications for Theory Development

The aims of this exploratory study came together in an effort to build towards a

theory of accreditation. Since no theory exists regarding how accreditation is meant to

work, a conceptual framework was developed to guide this study. Findings revealed

implications for further theory development.

Theory of intrinsic and extrinsic motivations originating from psychology (Ryan

& Deci, 2000) and applied to organizational behavior (Broedling, 1997) and behavioral

economics (Kreps, 1997) could help frame reasons why agencies pursue accreditation.

According to Ryan and Deci (2000), "intrinsic motivation is defined as the doing of an

activity for its inherent satisfactions…" (p. 56). In contrast, extrinsic motivation "pertains

to whenever an activity is done in order to attain some separable outcome" (p. 60). This

could include external pressures or rewards. Though extrinsic factors such as policies and

funders' requirements motivated agencies to pursue accreditation, agencies also shared their intrinsic motivation to become accredited. These intrinsic factors such as wanting to professionalize the agency for its growth and evolution, deserve more consideration in a theory of accreditation. The combination and interaction of intrinsic and extrinsic motivations could be more complex and could affect how agencies use accreditation. For example, while extrinsic motivations may push agencies towards accreditation, intrinsic motivations may help agencies go beyond temporarily meeting the minimum requirements and use accreditation to continuously improve quality.

The conceptual framework for this study proposed that organizational social context would affect agencies' experience with accreditation but, as mentioned above as a limitation, there was no pre and post data to make comparisons. However, the accreditation process was found to affect agencies' organizational social contexts according to interview and focus group information. For example, employees at all of the agencies shared how the accreditation process influenced organizational culture, climate, and work attitudes, such as stress and morale.

This study explored agencies' perspectives the conceptual framework, but for further theory development, the views of consumers and accreditors need to be incorporated in future studies. This will be discussed in the following section on implications for research.

Implications for Research

Research on accreditation is in its infancy. Many types of accreditation studies are needed. This study can be considered a step toward many of these types of studies. To

maintain accreditation's appeal and value, policies recognizing accreditation need to be supported with evidence about its ability to improve agencies and consumer outcomes and take consumers' perspectives into account. This discussion starts with how this study could inform future studies. Then, the major unanswered questions in accreditation research are delineated.

This study's participants did not generate many concrete examples of how accreditation works. To complement and supplement the agencies' perspectives examined in this study, future research could add to the accreditors' perspectives. For example, researchers could partner with each of the accreditors—COA, CARF, and the Joint Commission—in order to learn how each accreditor believe accreditation is supposed to work. What, exactly, are they trying to change and how are they trying to change it? Then, agency and accreditor perspectives on accreditation could be compared.

This study highlighted a variety of reasons for why agencies sought accreditation. During the recruitment process, I found that some agencies stopped the COA process or had chosen a different accreditor. Other studies could focus on understanding the trends regarding why agencies decide or decide not to pursue accreditation. A national survey of social service and/or mental health agencies could reveal accreditation rates and the reasons behind them. These data could be combined with Geographical Information System (GIS) methods to map accreditation trends and study whether accreditation rates differ across regions and explore reasons why. This could increase our understanding of the how various policies affect accreditation rates throughout the country.

Given the growth of accreditation and the paucity of evidence related to its effectiveness, accreditation needs to be rigorously evaluated in order to fully understand

its impact. Experimental studies or randomized control trials could "test cause and effect relationships as predicted by theory" (Drake & Jonson-Reid, 2008, p. 74). Based on a theory of how accreditation is meant to work, its impact on outcomes can be evaluated. While it may not be plausible to employ randomized control trials, ex post facto quasi-experimental studies could compare pre-accreditation and post-accreditation data from accredited and non accredited organizations. Risk adjustment techniques could control for case mix issues and propensity score matching could control for selection bias. More empirical evidence will reveal if and how accreditation truly makes a difference for agencies and clients.

<p style="text-align:center">Conclusion</p>

While the potential for accreditation as a leverage point for quality has yet to be determined, thousands of agencies are spending considerable amounts of money and resources towards achieving and maintaining accreditation. Further streamlining the accreditation standards and making them more explicitly evidence-based and designed to promote evidence-based practice could lead to improved quality of services. In addition, focusing on standards that can make a difference could lessen the burden of the self-study for agencies. In the end, it is up to each agency if and how they use accreditation as a tool for quality improvement.

Accreditation is a costly and time consuming endeavor that influences the lives and workings of agencies, yet the evidence on how it can most effectively be used to improve mental health care is lacking. This study is a step towards understanding the accreditation phenomenon. Much more research is needed to maximize accreditation's

potential to improve service delivery and outcomes for the millions served by accredited

organizations.

REFERENCES

Abe-Kim, J. S., & Takeuchi, D. T. (1996). Cultural competence and quality of care: Issues for mental health service delivery in managed care. *Clinical Psychology: Science and Practice, 3*(4), 273-295.

Abuhamad, A., Benacerraf, B., Woletz, P., & Burke, B. (2004). The accreditation of ultrasound

Adams, S. (2005). Does CACREP accreditation make a difference? A look at the NCE results and answers. *Journal of Professional Counseling Practice, Theory, and Research, 33*(2), 60-76.

Almgren, G. & Marcenko, M. (2001). Emergency room treatment among foster care sample: The influence of placement history, chronic illness, psychiatric diagnosis, and care factors. *Brief Treatment and Crisis Intervention*, *1*(1), 55-64.

Alstete, J. (2007). *College accreditation: Managing internal revitalization and public respect*. New York: Palgrave MacMillan.

Association of Community Human Service Agencies. (n.d.). *About ACHSA.* Retrieved July 6, 2008 from http://www.achsa.net/about/index.php

Ayres, I. & Braithwaite, J (1992). *Responsive regulation: Transcending the deregulation debate.* New York: Oxford University Press.

Baldwin, R. & Cave, M. (1999). *Understanding regulation: Theory, strategy, and practice.* New York: Oxford University Press.

Beaulieu, N. & Epstein, A. (2002). National Committee on Quality Assurance health-plan accreditation: Predictors, Correlates of Performance, and Market Impact. *Medical Care*, *40*(4), 325-337.

Bernard, H. R. (2006). *Research methods in anthropology: Qualitative and quantitative approaches.* Lanham, MD: AltaMira Press.

Bickman, L. & Noser, K. (1999). Meeting the challenges in the delivery of child and adolescent mental health services in the next millennium: The continuous quality improvement approach. *Applied and Preventive Psychology, 8*, 247-255.

Blalock, H. (1968). The measurement problem: A gap between the languages of theory and research. In H. M. Blalock & A. Blalock (Eds.). *Methodology in social research.* New York: McGraw-Hill Book Company.

Braithwaite, J., Westbrook, J., Pawsey, M., Greenfield, D., Naylor, J., Iedema, R., et al. (2006). A prospective, multi-method, multi-disciplinary, multi-level, collaborative, social-organisational design for researching health sector accreditation. *BMC Health Services Research, 6,* 113-123.

Brennan, T. A. & Berwick, D. M. (1996). *New rules: Regulation, markets, and the quality of American health care.* San Francisco: Jossey-Bass Publishers.

Brennan, T. A. (1998). The role of regulation in quality improvement. *The Milbank Quarterly, 76*(4), 709-731.

Breyer, S. (1982). *Regulation and its reform.* Cambridge, Massachusetts: Harvard University Press.

Broedling, L. A.. (1977). The uses of intrinsic-extrinsic distinction in explaining motivation and organizational behavior. *Academy of Management Review*, 2(2), 267-276.

Brommel, S. M. (2006). A historical analysis: The Council on Accreditation for Children and Family Services. (Doctoral dissertation, University of Minnesota, 2006). *Dissertation Abstracts International*, 67/08.

Brook, R. H., McGlynn, E.A.., & Cleary, P.D. (1996). Quality of health care part II: Measuring quality of care. *New England Journal of Medicine*, 335, 966-970.

Carman, G. (1996). How can evaluation help the agency with licensing, funding, and accreditation?. In P. Pecora, W. Seelig, F. Zirps, & S. Davis (Eds.) *Quality improvement and evaluation in child and family services: Managing into the next century* (pp. 199-214). Washington, D.C.: Child Welfare League of America Press.

Center for Substance Abuse Treatment (CSAT) (2004). *Opioid treatment program accreditation impact study.* Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.

Cerqueira, M. (n.d.). *A literature review on the benefits, challenges, and trends in accreditation as a quality assurance system*. Retrieved September 17, 2007 from http://www.communitylivingbc.ca/what_we_do/innovation/pdf/literature_review_2006.pdf

Chamraz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* Sage Publications: Thousand Oaks, CA.

Chen, J., Rathmore, S., Radford, M., & Krumholz, H. (2003). JCAHO accreditation and quality of care for acute myocardial infarction. *Health Affairs, 22*(2), 243-254.

Child Welfare League of America. (n.d.). *Accreditation support services.* Retrieved July 9, 2008 from http://www.cwla.org/consultation/accreditation.htm

Commission on Accreditation of Rehabilitation Facilities. (2008). *Who we are.* Retrieved

   August 2, 2007 from

   http://www.carf.org/consumer.aspx?content=content/About/News/boilerplate.htm

Cooper, J. & Masi, R. (2007). *Child and youth emergency mental health care: A national*

   problem. Retrieved April 8, 2008 from http://www.nccp.org/publications/pub_0.html

Council on Accreditation. (n.d.). *The 8th edition standards.* Retrieved October 22, 2007

   from

   http://www.coanet.org/front3/page.cfm?sect=55&cont=4190#Development%20Proce

   ss

Council on Accreditation. (n.d.). *About Us*. Retrieved August 2, 2007 from

   http://www.coanet.org/front3/page.cfm?sect=1&cont=4320

Council on Accreditation. (n.d.). *Peer Reviewers/Team Leaders.* Retrieved January 8,

   2008 from http://www.coanet.org/front3/page.cfm?sect=5

Council on Accreditation. (n.d.). *Value of contextual accreditation.* Retrieved November

   1, 2007 from http://www.coanet.org.front3/page.cfm?sect=53

Council on Accreditation. (2007a). *Accreditation policies and procedures.* Retrieved

   January 9, 2008 from http://www.coanet.org/Files/P&PManualPriv.pdf

Council on Accreditation. (2007b). *Public accreditation report.* Retrieved December 1,

   2007 from http://www.coanet.org/Files/PubAgReport.pdf

Council on Accreditation. (2007c). *Recognition report.* Retrieved February 1, 2008 from

   http://www.coanet.org/Files/RR.pdf

Council on Accreditation. (2008a). *Administrative and Service Environment.* Retrieved

August 21, 2008 from

http://www.coastandards.org/standards.php?navView=private&section_id=49

Council on Accreditation. (2008b). *Glossary.* Retrieved August 1, 2008 from

http://www.coastandards.org/glossary/php

Council on Accreditation. (2008c). *How are the standards organized?.* Retrieved August

21, 2008 from http://www.coastandards.org/p_g_06_organized.php

Council on Accreditation. (2008d). *Performance and quality improvement.* Retrieved

August 21, 2008 from

http://www.coastandards.org/standards.php?navView=private&section_id=75

Council on Accreditation. (2008e). *Private standards.* Retrieved September 12, 2007

from http://www.coastandards.org/standards.php?navView=private

Council on Accreditation. (2008f). *Residential treatment services: Assessment.* Retrieved

August 21, 2008 from

http://www.coastandards.org/standards.php?navView=private&core_id=1019

Council on Accreditation. (2008g). *Residential treatment services: Definition.* Retrieved

September 27, 2008 from

http://www.coastandards.org/standards.php?navView=private&section_id=93

Council on Accreditation. (2008h). *Residential treatment services: Personnel.* Retrieved

August 21, 2008

http://www.coastandards.org/standards.php?navView=private&core_id=1020

Council on Accreditation. (2008i). *Residential treatment services: Service planning and monitoring.* Retrieved August 21, 2008

http://www.coastandards.org/standards.php?navView=private&core_id=1020

Council on Accreditation. (2008j). *Sample fee scale.* Retrieved January 24, 2008 from

http://www.coanet.org/front3/page.cfm?sect=14&cont=3134

Council on Accreditation. (2008k). *Training and supervision.* Retrieved August 21, 2008 from http://www.coastandards.org/standards.php?navView=private&core_id=550

Council on Accreditation (2008l). *What is a standard and how is it assigned?.* Retrieved November 18, 2007 from http://www.coastandards.org/p_g_05_standard.php

Creswell, J. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches*. Thousand Oaks, CA: Sage Publications.

Crosby, P. (1979). *Quality is free: The art of making quality certain.* New York: McGraw-Hill.

DeBritz, J & Pollak, A. (2006). The impact of trauma centre accreditation on patient outcome. *Injury*, *37,* 1166-1171.

Demetriades, D., Martin, M., Salim, A., Rhee, P., Brown, C., & Chan, L. (2005). The effect of trauma center designation and trauma volume on outcome in specific severe injuries. *Annals of Surgery, 242*(4), 512-519.

Deming, W. E. (1986). *Out of the crisis*. Cambridge, MA: MIT Center for Advanced Engineering.

DiCiccio-Bloom, B. & Crabtree, B. (2006). The qualitative research interview. *Medical Education, 40,* 314-321.

DiRusso, S., Holly, C., Kamath, R., & Cuff, S. (2001). Preparation and achievement of American College of Surgeons level I verification raises hospital performance and improves patient outcome. *Journal of Trauma, 51,* 294-300.

Donabedian, A. (1988). The quality of care: How can it be assessed? *Journal of the American Medical Association*, *260*(12), 1743-1748.

Drake, B. & Jonson-Reid, M. (2008). *Social work research methods: From conceptualization to dissemination*. Boston, MA: Pearson Education.

Duckett, S. J. & Coombs, E. M. (1981). The emphasis and effect of hospital accreditation on nursing services. *International Journal of Nursing Studies, 18*(3), 177-184.

Duckett, S. J. (1983). Changing hospitals: The role of hospital accreditation. *Social Science of Medicine, 17*(20), 1573-1579.

Edmunds, M., Frank, R., Hogan, M., McCarty, D., Robinson-Beale, R., & Weisner, C. (1997). *Managing managed care: Quality improvement in behavioral health*. Washington, D.C.: National Academy Press.

El-Jardali, F., Jamal, D., Dimassi, H., Ammar, W., & Tchaghchaghian, V. (2008). The impact of hospital accreditation on quality of care: Perception of Lebanese nurses. *International Journal of Quality in Healthcare, 20(*8), 363-371.

Feigenbaum, A. V. (1983). *Total quality control.* New York: McGraw-Hill.

Frasco, P., Sprung, J., & Trentman, T. (2005). The impact of the Joint Commission for Accreditation of Healthcare Organizations pain initiative on perioperative opiate consumption and recovery room length of stay. *Anesthesia and Analgesia, 100,* 162-168.

Freund, D. & Lichtenberg, F. (2000). *The impact of hospital quality-related practices on health outcomes*. Syracuse, New York: Center for Policy Research.

Gilchrist, V. & Williams, R. (1999). Key informant interviews. In B. Crabtree & W. Miller, W (Eds.) *Doing qualitative research* (pp. 71-86). Beverly Hills, CA: Sage Publications.

Giraud, A. (2001). Accreditation and the quality movement in France. *Quality in Healthcare, 10,* 111-116.

Glisson, C. (2002). The organizational context of children's mental health services. *Clinical Child and Family Psychology Review, 5*(4), 233-253.

Glisson, C., Dukes, D., & Green, P. (2006). The effects of the ARC organizational intervention on caseworker turnover, climate, and culture in children's service systems. *Child Abuse and Neglect, 30*, 855-880.

Glisson, C. & Green, P. (2006). The effects of organizational culture and climate on the access to mental health care in child welfare and juvenile justice systems. *Administration and Policy in Mnetal Health and Mental Health Services Research, 33*(4), 433-448.

Glisson, C. & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect, 22*, 401-421.

Glisson, C. & James, L. (2002). The cross-level effects of culture and climate in human service-teams. *Journal of Organizational Behavior, 23*, 767-794.

Glisson, C., Landsverk, J., Schoenwald, S., Kelleher, K., Hoagwood, K., Mayberg, S., et al. (2008). Assessing the organizational social context (OSC) of mental health

services: Implications for research and practice. *Administration and Policy in Mental Health, 35*, 98-113.

Glisson, C., Schoenwald, S., Kelleher, K., Landsverk, J., Hoagwood, K., Mayberg, S. et al., (2008). Therapist turnover and new program sustainability in mental health clinics as a function of organizational culture, climate, and service structure. *Administration and Policy in Mental Health, 35*, 124-133.

Hadley, T. & McGurrin, M. (1988). Accreditation, certification, and the quality of care in state hospitals. *Hospital and Community Psychiatry*, *39*(7), 739-742.

Hatch, M. J. & Cunliffe, A. L. (2006). *Organizational theory: Modern, symbolic, and postmodern perspectives*. Oxford: Oxford University Press.

Hazard, N., Pacinella, S., & Pietrass, J. (2002). *The impact of Accreditation on organizational functioning and performance*. New York: Council on Accreditation, Inc..

Heras, I., Dick, G., & Casadesus, M. (2002). ISO 9000 registration's impact on sales and profitability: A longitudinal analysis of performance before and after accreditation. *International Journal of Quality and Reliability Management, 19*(6), 771-791.

Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. Washington, D.C.: National Academy of Sciences.

The Joint Commission. (n.d.). *Behavioral health care*. Retrieved August 2, 2007 from http://jointcommission.org/AccreditationPrograms/BehavioralHealthCare/ed_bhc.htm

Juran, J. (1989). *Juran on leadership for quality: An executive handbook.* New York: Free Press.

Kassebaum, D., Cutler, E., & Eaglen, R. (1997). The influence of accreditation on

   educational change in U.S. medical schools. *Academic Medicine, 72*(12), 1128-1133.

Kreps, D. M. (1997). Intrinsic motivation and extrinsic incentives. *The American*

   Economic Review, 87(2), 359-364

Krueger, R. A. & Casey, M. A. (2000). Focus *groups: A practical guide for applied*

   research. Thousand Oaks, CA: Sage Publications, Inc..

Marsh, J. (2003). Organizational and institutional factors in the development of practice

   knowledge and practice guideline in social work. In A. Rosen & E. Proctor (Eds.)

   Developing practice guideline for social work intervention: Issues, methods, and

   research agenda (pp. 236-252). New York: Columbia University Press.

Martin, L. L. (1993). *Total quality management in human service organizations*.

   Newbury Park, California, Sage Human Services Guide.

Masi, R. & Cooper, J. (2006). *Children's mental health: Facts for policymakers.*

   Retrieved April 8, 2008 from http://www.nccp.org/publications/pub_687.html

Mays, G. (2004). *Can accreditation work in public health?: Lessons from other service*

   industries. Retrieved September 2, 2007 from

   http://www.rwjf.org/files/publications/other/publichealth_Mayssummary.pdf

Mazmanian, P., Krutzer, J., Devany, C., & Martin, C. (1993). A survey of accredited and

   other rehabilitation facilities: education, training, and cognitive rehabilitation in

   brain-injury programmes. *Brain Injury*, *7*(4), 319-331.

McMillen, J. C., Proctor, E. K., Megivern, D., Striley, C., Cabassa, L., Munson, M., et al.

   (2005). Quality of care in social services: Research agenda and methods. *Social Work*

   Research, 29(3), 181-191.

Megivern, D. M., McMillen, J. C., Proctor, E. K., Striley, C. L. W., Cabassa, L. J., &
Munson, M. R. (2007). Quality of care: Expanding the social work dialogue. *Social
Work*, *52*(2), 115-124.

Miller, M., Pronovost, P., Donithan, M., Zeger, S., Zhan, C., Morlock, L., et al. (2005).
Relationship between performance measure and accreditation: Implications for
quality of care and patient safety. *American Journal of Medical Quality*, *20*(5), 239-
252.

Moffett, M. & Bohara, A. (2005). Hospital quality oversight by the Joint Commission on
the Accreditation of Healthcare Organizations. *Eastern Economic Journal*, *31*(4),
629-647.

Morgan, D. L. & Krueger, R. A. (1993). When to use focus groups and why. In D. L.
Morgan (Ed.), *Successful focus groups: Advancing the state of the art.* Newbury Park,
CA: Sage Publications, Inc..

Nabors, L. A., Weist, M. D., Holden, E., & Tashman, N. A. (1999). Quality service
provision in children's mental health care. *Children's Services: Social Policy,
Research, and Practice, 2*(2), 57-79.

National Institute of Mental Health. (2008a). *Division of Services and Intervention
Research (DSIR).* Retrieved on June 21, 2008 from
http://www.nimh.nih.gov/about/organization/dsir/index.shtml

National Institute of Mental Health. (2008b). *The National Institute of Mental Health
Strategic Plan*. Retrieved August 2, 2008 from
http://www.nimh.nih.gov/about/strategic-planning-reports/

Nichols, A..W. (1980). Accreditation in the field of social welfare: An approach to self-regulation and social control. (Doctoral dissertation, Columbia University School of Social Work, 1980). *Dissertation Abstracts International*, 41 (4-A), 1776.

Nichols, A. W. & Schilit, R. (1992). Accreditation of human service agencies: Costs, benefits, and issues. *Administration in Social Work, 16*(1), 11-23.

Osborne, D. & Garbler, T. (1997). *Reinventing government: How the entrepreneurial spirit is transforming the public sector*. Reading, MA: Addison-Wesley Books.

Pasquale, M., Peitzman, A., Bednarski, J., & Wasser, T. (2001). Outcome analysis of Pennsylvania trauma centers: Factors predictive of nonsurvival in seriously injured patients. *The Journal of Trauma, Injury, Infection, and Critical Care, 50*(3), 465-474.

Pomey, M-P., Contandriopoulos, A-P., Francois, P., & Bertrans, D. (2004). Accreditation: A tool for organizational change in hospitals?. *International Journal of Healthcare Quality Assurance*, *1793,* 113-124.

Porter, M. (1980). *Competitive strategy: Techniques for analyzing industries and competitors.* New York: The Free Press.

Pottick, K., Warner, L., & Yoder, K. (2005). Youths living away from families in the United States mental health system: Opportunities for targeted intervention. *Journal of Behavioral Health Services and Research, 32*(3), 264-281.

Qualitative Solutions and Research. (2006). *NVivo 7.0.: Using NVivo in qualitative research.* Melbourne, Australia: QSR International.

Raghavan, R., Inkelas, M., Franke, T., & Halfon, N. (2007). Administrative barriers to the adoption of high-quality mental health services for children in foster care: A

national study. *Administration and Policy in Mental Health and Mental Health Services Research, 34,* 191-201.

Roberts, J. S., Coale, J. G., & Redman, R. R. (1987). A history of the Joint Commission on Accreditation of Hospitals. *Journal of the American Medical Association*, *258*(7), 936-940.

Ryan, R. M. & Deci, E. L. (2000). Intrinsic and extrinsic motivations: Classic definitions and new directions. *Contemporary Educational Psychology*, 25, 54-67.

Saint Louis Outcomes and Evaluation Network (SLOEN). (n.d.). *Who we are.* Retrieved June 29, 2008 from http://sloen.org/

Salmon, J., Heavens, J., Lombard, C., & Tavrow, P. (2003). The impact of accreditation in the quality of hospital care: KwaZulu-Natal Province, Republic of South Africa. Retrieved September 17, 2007 from
http://www.qaproject.org/pubs/PDFs/SAfrAccredScreen.pdf

Sampalis, J., Lavole, A., Boukas, S., Tamim, H., Nikolis, A., Frechette, P., et al. (1995). Trauma center designation: Initial impact on trauma-related mortality. *The Journal of Trauma, Injury, Infection, and Critical Care, 39*(2), 232-239.

Schafer Consulting. (n.d.). *Behavioral health and human services business consultant.* Retrieved July 9, 2008 from http://www.schaferconsulting.com/

Selden, W. K. (1960). *Accreditation: A struggle over standards in higher education*. New York: Harper and Brothers Publishers.

Shortell, S. M., Marsteller, J. A., Lin, M., Pearson, M. L., Wu, S., Mendel, P., Cretin, S., & Rosen, M. (2004). The role of perceived team effectiveness in improving chronic illness care. *Medical Care, 42*(11), 1040-1048.

Shortell, S. M., O'Brien, J. L., Carman, J. M., Foster, R. W., Hughes, E. F. X., Boerstir, H. &

O'Connor, E. J. (1995). Assessing the impact of continuous quality improvement/total quality management: Concept versus implementation. *Health Services Research*, *30*(2), 377-401.

Simons, R., Kasic, S., Kirkpatrick, A., Vertesi, L., Phang, T., & Appleton, L. (2002). Relative importance of designation and accreditation of trauma centers during evolution of a regional trauma system. *The Journal of Trauma, Injury, Infection, and Critical Care*, *52,* 827-834.

Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage Publications.

Stake, R. E. (2006). *Multiple case study analysis*. New York: The Guilford Press.

Stratton, P., Reece, T., & Chesire, J. (2004, March). *Accreditation and program reviews as interventions to improve treatment process and outcomes for child mental health: Evaluation of all residential treatment programs for children in Kentucky for a three-year period.* Paper presented at the 50th Annual Program Meeting of the Council on Social Work Education, Anaheim, CA.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedure and techniques*. Newbury Park, CA: Sage Publications.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General.* Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

U.S. General Accountability Office. (2008, April). Residential facilities: State and federal oversight gaps may increase risk to youth well-being. (Publication No. GAO-08-696T). Retrieved May 15, 2008 from http://www.gao.gov/new.items/d08696t.pdf

U.S. House of Representatives Committee on Government Reform. (2004). *Incarceration of youth who are waiting for community mental health services in the United States.* Retrieved from http://www.house.gov/reform/min/pdfs_108_2/pdfs_inves/pdf_health_mental_health _youth_incarceration_july_2004_rep.pdf

Van Slyke, D. & Roch, C. (2004). What do they know, and whom do they hold accountable? Citizens in the government-nonprofit contracting relationship. *Journal of Public Administration Research and Theory*, *14*(2), 191-209.

Viswanathan, H. N. & Salmon, J. W. (2000). Accrediting organizations and quality improvement. *The American Journal of Managed Care, 6*(10), 1117-1130.

Volkwein, J., Lattuca, L., Harper, H., & Domingo, R. (2006). Measuring the impact of professional accreditation on student experiences and learning outcomes. *Research in Higher Education*, *48*(2), 251-282.

Weissman, H. H. (1980). Accreditation, credentialing, and accountability. *Administration in Social Work, 4*(4), 41-52.

Whitebook, M., Sakai, L., & Howes, C. (1997). *NAEYC accreditation as a strategy for improving child care quality: An assessment by the National Center for the Early Childhood Work Force.* Washington, D.C.: National Center for the Early Childhood Work Force.

Yin, R. (1984). *Case study research: Design and methods.* Beverly Hills, CA: Sage Publications.

Zeithaml, V., Parasuraman, A., & Berry, L. (1990). *Delivering quality service: Balancing customer perceptions and expectations*. New York: The Free Press.

Zellman, G., Johansen, A., & Winkle, J. (1994). *Examining the effects of accreditation on military child development center operations and outcomes.* Santa Monica: RAND. Retrieved September 18, 2007 from http://stinet.dtic.mil/cgi-fbin/GetTRDoc?AD=ADA290927&Location=U2&doc=GetTRDoc.pdf

Zima, B., Hurlburt, M., Knapp, P., Ladd, H., Tang, L., Duan, N. et al. (2005). Quality of publicly funded outpatient specialty mental health care for common childhood psychiatric disorders in California. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*(2), 130-144.

Appendix A: Key Informant Qualitative Interview Protocol

The first question focuses on your agency's motivations to pursue accreditation.

1. What motivated the agency to pursue accreditation? Can you tell me the story of how this agency chose to pursue COA accreditation?
> PROBES: What was going on at the agency at the time that may have led to the decision to pursue accreditation?
> Why did this agency seek accreditation?
> What did/do you hope accreditation will accomplish?
> How did this agency come to choose COA accreditation?
> What did you consider in your decision?

The next several questions focus on your experience with various aspects of the accreditation process—your involvement, the burdens, and benefits.

2. How involved were you in the self-study process?
3. What were some of the difficult parts of the self-study process? What was the worst part?
> PROBES: Can you describe the burden the self-study placed on you?
> What didn't get done because you were working on the self-study?
> What were the biggest challenges the self-study posed for you and your job?
4. What was the most helpful or beneficial part of the self-study process?
> PROBES: Can you give me examples of something that was implemented due to the self-study process?
> Can you give me examples of something you learned due to the self-study process?

5. How involved were you in preparing for the site visit? How involved were you during the actual site visit?
6. What were some of the difficult parts of the site visit process? What was the worst part?
> PROBES: Can you describe the burden the site visit placed on you?
> What didn't get done because you were working on preparing for the site visit?
> What were the biggest challenges the site visit posed for you and your job?
7. What was the most helpful or beneficial part of the site visit process?
> PROBES: Can you give me examples of something that was implemented due to the site visit process?
> Can you give me examples of something you learned due to the site visit process?

8. How involved were you in responding to COA's pre-commission report?
9. What were some of the difficult parts of responding to COA's pre-commission report? What was the worst part?
> PROBES: Can you describe the burden responding to the pre-commission report placed on you?
> What didn't get done because you were working on responding to the pre-commission report?
> What were the biggest challenges responding to the pre-commission report posed for you and your job?

10. What was the most helpful or beneficial part of pre-commission report?
> PROBES: Can you give me examples of something that was implemented due to responding to the pre-commission report?

Can you give me examples of something you learned due to responding to the pre-commission report?

The final questions focus on your perceptions of the accreditation process—its impact and how it might be improved.

11. What do you think has changed at this agency as a result of the accreditation process?
     PROBE: Overall, how has accreditation impacted this agency's service quality?
     PROBE: How has accreditation affected agency culture, climate, and attitudes?

12. Does your agency use evidence-based practices? If so, has accreditation promoted EBPs? How?

13. Overall, what did you think about the accreditation process?
14. How do you think accreditation could be structured or changed to be more beneficial for agencies?

Appendix B. Focus Group Protocol

Thank you very much for being here this morning/afternoon. My name is Madeline Lee and I am a doctoral student in social work at Washington University in St. Louis. I am working on my dissertation project to understand how agencies experience COA accreditation. I hope that our discussion today is a chance for you all to share your thoughts and experiences so that we can have a better understanding of how accreditation works in order to make accreditation a more effective tool for quality improvement.

We'll begin with introductions and then I'll ask some questions about the accreditation experience; the challenges and benefits, your perceptions of accreditation, and how you think it could be structured or changed to be more beneficial for agencies. This should only take about one hour. I'm very interested in what you have to say and hope you'll share all the things you think are important for me to know. All the ideas that you have are important for this study, even if you think they are minor or unimportant.

Your participation is completely voluntary. You do not have to answer any questions that you do not want to answer. I will record this session so that we can return to any of your statements that might help us to understand your experiences. I can turn off the recorder at any time if you would rather say something you don't want recorded.

The risk of participating in this focus group is minimal. Everything that you say will be kept strictly confidential. Your name will not be linked to any comments that you make and we also ask everyone here not to share in public whatever we discuss today. Be assured that none of the information shared here will be shared with your supervisors.

I ask that you please not talk over each other or carry side conversations because we really want to hear what each person has to say. I am very grateful for your valuable time.

Do you have any questions?

Let's go ahead and begin.

The first question focuses on your agency's motivations to pursue accreditation.

1. Can you tell me the story of how you first knew that this agency was pursuing COA accreditation? Why do you think your agency chose to pursue accreditation?
        PROBE: What was your initial reaction?

The next several questions focus on your experience with various aspects of the accreditation process—your involvement, the burdens, and benefits.

2. How involved were you in the self-study process?
3. What were some of the difficult parts of the self-study process? What was the worst part?
        PROBES: Can you describe the burden the self-study placed on you?
                      What didn't get done because you were working on the self-study?
                      What were the biggest challenges the self-study posed for you and your job?

4. What was the most helpful or beneficial part of the self-study process?
        PROBES: Can you give me examples of something that was implemented due to the self-study process?
                      Can you give me examples of something you learned due to the self-study process?

5. How involved were you in preparing for the site visit? How involved were you during the actual site visit?

6. What were some of the difficult parts of the site visit process? What was the worst part?
       PROBES: Can you describe the burden the site visit placed on you?
                    What didn't get done because you were working on preparing for the site visit?
                    What were the biggest challenges the site visit posed for you and your job?

7. What was the most helpful or beneficial part of the site visit process?
       PROBES: Can you give me examples of something that was implemented due to the site visit process?
                    Can you give me examples of something you learned due to the site visit process?

8. How involved were you in responding to the report from COA that had recommendations following the site visit (pre-commission report)?

9. What were some of the difficult parts of responding to COA's report? What was the worst part?
       PROBES: Can you describe the burden responding to the report placed on you?
                    What didn't get done because you were working on responding to the report?
                    What were the biggest challenges responding to the report posed for you and your job?

10. What was the most helpful or beneficial part of the report?
       PROBES: Can you give me examples of something that was implemented due to responding to the report?
                    Can you give me examples of something you learned due to responding to the report?

The final questions focus on your perceptions of the accreditation process—its impact and how it might be improved.

11. What do you think has changed at this agency as a result of the accreditation process?
       PROBE: Overall, how has accreditation impacted this agency's service quality?
       PROBE: How has accreditation affected agency culture, climate, and attitudes?

12. Overall, what did you think about the accreditation process?

13. How do you think accreditation could be structured or changed to be more beneficial for agencies?

SURVEY ON COA ACCREDITATION

Thank you very much for taking the time to complete this survey. Your responses will help increase our understanding of how accreditation works in order to make it a more effective tool for quality improvement.

All of your answers will be kept confidential. None of your answers will be shared with supervisors. Your participation is completely voluntary and it will neither positively nor negatively affect your performance evaluation.

This survey has two parts. The first part will ask you about your involvement in the accreditation process, how burdensome it was, as well as and the benefits of accreditation. The second part is a measure on organizational social context that will help us understand how agencies react to accreditation and under what circumstances accreditation is most effective.

---

1. How **involved** were you in the accreditation **self-study process**?
   - ☐ Not aware of the self-study process
   - ☐ Not at all
   - ☐ Somewhat involved
   - ☐ Involved
   - ☐ Extremely involved

2. How **burdensome** was the accreditation **self-study process** for you?
   - ☐ Not aware of the self-study process
   - ☐ Not at all
   - ☐ Somewhat burdensome
   - ☐ Burdensome
   - ☐ Extremely burdensome

3. How **involved** were you in the accreditation **site visit process**?
   - ☐ Not aware of the site visit process
   - ☐ Not at all
   - ☐ Somewhat involved
   - ☐ Involved
   - ☐ Extremely involved

4. How **burdensome** was the accreditation **site visit** for you?
   - ☐ Not aware of the site visit process
   - ☐ Not at all
   - ☐ Somewhat burdensome
   - ☐ Burdensome
   - ☐ Extremely burdensome

5. How **involved** were you in responding to recommendations on COA's **pre-commission report** (PCR), the report prepared by the COA site visitors?
   - ☐ Not aware of the PCR
   - ☐ Not at all
   - ☐ Somewhat involved
   - ☐ Involved
   - ☐ Extremely involved

6. How **burdensome** was responding to COA's **PCR** for you?
   - ☐ Not aware of the PCR
   - ☐ Not at all
   - ☐ Somewhat burdensome
   - ☐ Burdensome
   - ☐ Extremely burdensome

7. How **involved** do you anticipate that you will be in the **maintenance of accreditation**?
   - ☐ Not at all
   - ☐ Somewhat involved
   - ☐ Involved
   - ☐ Extremely involved

8. In your opinion, how much has the accreditation process improved the services delivered at this agency?
   - ☐ Not at all
   - ☐ Somewhat improved care
   - ☐ Improved care
   - ☐ Improved care a lot

9. In your opinion, how has the accreditation process affected this agency's culture (i.e. what it feels like to work here), climate (i.e. the agency's impact on you), and work attitudes (i.e. morale)?
   - ☐ Much better
   - ☐ Somewhat better
   - ☐ About the same
   - ☐ Somewhat worse
   - ☐ Much worse

The following statements are about the benefits of accreditation. Please rate to the extent you disagree or agree with each statement.

10. The accreditation process enabled the motivation of staff and encourages team work and collaboration.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neutral/No opinion
    - ☐ Agree
    - ☐ Strongly agree

11. The accreditation process enabled the development of values shared by all professionals at this agency.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neutral/No opinion
    - ☐ Agree
    - ☐ Strongly agree

12. The accreditation process enabled this agency to better use its internal resources (e.g. finances, people, time, and equipment).
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neutral/No opinion
    - ☐ Agree
    - ☐ Strongly agree

13. The accreditation process enabled this agency to better respond to the population's needs.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neutral/No opinion
    - ☐ Agree
    - ☐ Strongly agree

14. The accreditation process enabled this agency to better respond to its partners (other agencies and departments it contracts with).
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neutral/No opinion
    - ☐ Agree
    - ☐ Strongly agree

15. Accreditation contributes to the development of collaboration with partners in children's mental health.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neutral/No opinion
    - ☐ Agree
    - ☐ Strongly agree

16. The accreditation process is a valuable tool to implement changes.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neutral/No opinion
    - ☐ Agree
    - ☐ Strongly agree

17. This agency's participation in accreditation enables it to be more responsive when changes are to be implemented.
    - ☐ Strongly disagree
    - ☐ Disagree
    - ☐ Neutral/No opinion
    - ☐ Agree
    - ☐ Strongly agree

18. How do you think this agency has benefited from the accreditation process?

The University of Tennessee
Children's Mental Health Services
Research Center

Organizational Social Context (OSC)

General Instructions

Please Read Carefully Before Answering

1. Please answer all items. If an item does not completely apply to your situation, try to select the closest or best answer from the alternatives given.

2. Use a No. 2 pencil only. Do not use ink, ballpoint or felt tip pens.

3. Make solid marks that fill the reponse completely.

4. Erase cleanly any marks you wish to change.

CORRECT: ●   INCORRECT: ⊘⊠◖◔

Organization: _____   Date: __/__/__
Month   Day   Year

PLEASE DO NOT WRITE IN THIS AREA

■■■○○○■■■■■○■■○○○○○○○○○○   14279

Column headers (both sides): Never | Almost Never | Sometimes | Almost Always | Always

#	Question	Never	Almost Never	Sometimes	Almost Always	Always
1	How often do your coworkers show signs of stress?	○	○	○	○	○
2	I have to ask a supervisor or coordinator before I do almost anything.	○	○	○	○	○
3	I really care about the fate of this organization.	○	○	○	○	○
4	I can easily create a relaxed atmosphere with the clients I serve.	○	○	○	○	○
5	Members of my organizational unit are expected to have up-to-date knowledge.	○	○	○	○	○
6	How often does your job interfere with your family life?	○	○	○	○	○
7	I understand how my performance will be evaluated.	○	○	○	○	○
8	How satisfied are you with the chance to do something that makes use of your abilities?	○	○	○	○	○
9	Members of my organizational unit are expected to avoid being different.	○	○	○	○	○
10	I feel like I'm at the end of my rope.	○	○	○	○	○
11	I am willing to put in a great deal of effort in order to help this organization be successful.	○	○	○	○	○
12	I feel exhilarated after working closely with the clients I serve.	○	○	○	○	○
13	Members of my organizational unit are expected to be critical.	○	○	○	○	○
14	The same procedures are to be followed in most situations.	○	○	○	○	○
15	A person can make his or her own decisions without checking with anyone else.	○	○	○	○	○
16	I feel I treat some of the clients I serve as impersonal objects.	○	○	○	○	○
17	Members of my organizational unit are expected to improve the well-being of each client.	○	○	○	○	○
18	I have accomplished many worthwhile things in this job.	○	○	○	○	○
19	How satisfied are you with the chances for advancement?	○	○	○	○	○
20	Once I start an assignment, I am not given enough time to complete it.	○	○	○	○	○
21	Members of my organizational unit are expected to evaluate how much we benefit clients.	○	○	○	○	○
22	To what extent are the objectives and goals of your position clearly defined?	○	○	○	○	○

23. This organization provides numerous opportunities to advance if you work for it.

24. We usually work under the same circumstances day to day.

25. Members of my organizational unit are expected to stay uninvolved.

26. I deal very effectively with the problems of the clients I serve.

27. My job responsibilities are clearly defined.

28. I am proud to tell others that I am part of this organization.

29. Members of my organizational unit are expected to criticize mistakes.

30. How satisfied are you with the freedom to use your own judgment?

31. This organization emphasizes growth and development.

32. When I face a difficult task, the people in my organization help me out.

33. Members of my organizational unit are expected to place the well-being of clients first.

34. I find that my values and the organization's values are very similar.

35. People here always get their orders from higher up.

36. No matter how much I do, there is always more to be done.

37. Members of my organizational unit are expected to find ways to serve clients more effectively.

38. I know what the people in my organization expect of me.

39. I feel fatigued when I get up in the morning and have to face another day on the job.

40. To what extent do your coworkers trust each other?

41. Members of my organizational unit are expected to avoid problems.

42. How satisfied are you with the feeling of accomplishment you get from your job?

43. There is only one way to do the job - the boss's way.

44. This organization rewards experience, dedication and hard work.

45. Members of my organizational unit are expected to be stern and unyielding.

PLEASE DO NOT WRITE IN THIS AREA

14279

	Never	Almost Never	Sometimes	Almost Always	Always
46. We are to follow strict operating procedures at all times.	O	O	O	O	O
47. I feel used up at the end of the workday.	O	O	O	O	O
48. I feel I'm positively influencing other people's lives through my work.	O	O	O	O	O
49. Members of my organizational unit are expected to act in the best interest of each client.	O	O	O	O	O
50. People here do the same job in the same way everyday.	O	O	O	O	O
51. Members of my organizational unit are expected to become more effective in serving clients.	O	O	O	O	O
52. I talk up this organization to my friends as a great organization to work for.	O	O	O	O	O
53. In my work, I am calm in dealing with the emotional problems of others.	O	O	O	O	O
54. Members of my organizational unit are expected to be competitive with coworkers.	O	O	O	O	O
55. How satisfied are you with the prestige your job has within the community?	O	O	O	O	O
56. Whenever we have a problem, we are supposed to go to the same person for an answer.	O	O	O	O	O

	Never	Almost Never	Sometimes	Almost Always	Always
57. There can be little action until a supervisor or coordinator approves the decision.	O	O	O	O	O
58. Members of my organizational unit are expected to go along with group decisions.	O	O	O	O	O
59. I feel burned out from my work.	O	O	O	O	O
60. I have become more callous towards people since I took this job.	O	O	O	O	O
61. Any decision I make has to have a supervisor's or coordinator's approval.	O	O	O	O	O
62. Members of my organizational unit are expected to strive for excellence.	O	O	O	O	O
63. Rules and regulations often get in the way of getting things done.	O	O	O	O	O
64. How satisfied are you with being able to do things the right way?	O	O	O	O	O
65. Interests of the clients are often replaced by bureaucratic concerns (e.g., paperwork).	O	O	O	O	O
66. Members of my organizational unit are expected to interact positively with others.	O	O	O	O	O
67. There is a feeling of cooperation among my coworkers.	O	O	O	O	O

68. To what extent is it possible to get accurate information on policies and administrative procedures?

69. How satisfied are you with the chance to try your own approaches to working with clients?

70. Members of my organizational unit are expected to learn new tasks.

71. How well are you kept informed about things that you need to know?

72. How often is there friction among your coworkers?

73. To what extent are you constantly under heavy pressure on your job?

74. Members of my organizational unit are expected to follow rather than lead.

75. How satisfied are you with the chance to do things for clients?

76. This organization really inspires the very best in me in the way of job performance.

77. I have to do things on my job that are against my better judgment.

78. Members of my organizational unit are expected to be dominant and assertive.

79. There are not enough people in my organization to get the work done.

80. There are more opportunities to advance in this organization than in other jobs in general.

81. How often do you end up doing things that should be done differently?

82. Members of my organizational unit are expected to be available to each client we serve.

83. The amount of work I have to do keeps me from doing a good job.

84. I am extremely glad that I chose to work for this organization.

85. How things are done around here is left pretty much up to the person doing the work.

86. Members of my organizational unit are expected to pay attention to details.

87. I feel emotionally drained from my work.

88. It's hard to feel close to the clients I serve.

Column headers (left and right): Never / Almost Never / Sometimes / Almost Always / Always

89. How satisfied are you with the recognition you get for doing a good job? ○ ○ ○ ○ ○

90. Members of my organizational unit are expected to not make waves. ○ ○ ○ ○ ○

91. The same steps must be followed in processing every piece of work. ○ ○ ○ ○ ○

92. How often do you have to bend a rule in order to carry out an assignment? ○ ○ ○ ○ ○

93. I worry that this job is hardening me emotionally. ○ ○ ○ ○ ○

94. Members of my organizational unit are expected to be number one. ○ ○ ○ ○ ○

95. I feel I'm working too hard on my job. ○ ○ ○ ○ ○

96. How often do you feel unable to satisfy the conflicting demands of your supervisors? ○ ○ ○ ○ ○

97. For me this is the best of all possible organizations to work for. ○ ○ ○ ○ ○

98. Members of my organizational unit are expected to plan for success. ○ ○ ○ ○ ○

99. I feel that I am my own boss in most matters. ○ ○ ○ ○ ○

100. Members of my organizational unit are expected to be thoughtful and considerate. ○ ○ ○ ○ ○

101. Opportunities for advancement in my position are much higher compared to those in other positions. ○ ○ ○ ○ ○

102. Members of my organizational unit are expected to defeat the competition. ○ ○ ○ ○ ○

103. At times, I find myself not really caring about what happens to some of the clients. ○ ○ ○ ○ ○

104. Inconsistencies exist among the rules and regulations that I am required to follow. ○ ○ ○ ○ ○

105. Members of my organizational unit are expected to be responsive to the needs of each client. ○ ○ ○ ○ ○

PLEASE DO NOT WRITE IN THIS AREA

14279

Demographic Questions

We are asking the following questions to determine if individuals with different backgrounds see their work in a similar manner.

Your responses are completely confidential.

1. What is your organizational code?

2. How many years of experience, including your present job, have you had in full-time human services work?

Note: Please round to the nearest year or enter zero (0) if you have worked less than six months.

3. How many years have you worked in your present agency?

Note: Please round to the nearest year or enter zero (0) if you have worked less than six months.

4. What is your position within the organization?

- ○ Primarily a provider of direct services to clients/customers.
- ○ Primarily a supervisor of those who provide direct services.
- ○ Upper management.
- ○ Other _____

5. What is your age?

6. What level of education have you completed?

- ○ High school graduate
- ○ Associate degree
- ○ Bachelor's degree
- ○ Masters degree
- ○ Doctoral degree

7. What major is your highest degree?

- ○ Education
- ○ Social Work
- ○ Nursing
- ○ Medicine
- ○ Psychology
- ○ Other _____

8. What is your race? *(You may choose more than one.)*

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or other Pacific Islander
- ○ Other
- ○ White

Code for Office Use Only

9. Are you of Hispanic or Latino origin?

- ○ Yes
- ○ No

10. What is your gender?

- ○ Male
- ○ Female

Appendix D. Document Review Data Collection Guide and Form

- Ask the site liaison in advance of the visit who has access to documents related to accreditation.
- Ask to set up times to discuss the documents and tell the site liaison and others in advance that you would like to have copies of some key documents, if possible, as long is there is no client identifying information.
- Ask regarding how and when the documents were developed and who had input into its development.
- Take detailed notes regarding the purpose and use of the documents.

Agency: _____   Date: _____

Self-Study
        Continuous Quality Improvement Plan
        Annual report
        Quarterly case reviews
        Corrective action plans
        Accidents, incidents, grievances
        Use of evidence-based practices

Pre-Commission Report
        Number of recommendations
        The nature of recommendations

Issue raised in survey/interview: Participant ID: Date:	Document reviewed for triangulation: Results from document:

Appendix E. Limited Observation Data Collection Guide and Form

To ask during observations:
- For a map of the facilities
- History of the agency
- History of the facilities
- Use and maintenance of the facilities
- Plans for facility changes
- Relationship of the agency with the immediate community

Agency:

| Activity:
Date:
Time: am/pm

Employees Present: | Organizational Social Context: |
| | Structural Indicators:

Process Indicators:

Outcome Indicators: |

Appendix F. Cross-Case Analysis Tables

Aim 1: To understand agencies' motivations to pursue accreditation and specifically, accreditation with COA. What were their reasons for seeking accreditation? What do they hope accreditation will accomplish? This study will explore if various reasons for pursing accreditation could affect the impact of accreditation at the agencies.

MERGED/SPECIAL FINDINGS	AGENCY #01	AGENCY #02	AGENCY #03	AGENCY #04	AGENCY #05
Why COA?	COA fit best	COA accredited agencies were satisfied with COA	COA is most recognized	COA fit better with state contract, outcomes based, considered CARF	COA more applicable, considered Joint Commission
Using accreditation as a platform for change, evolution of the agency	Time for professionalizing, new leadership, consistency	New ED wanted to make changes and formalize, accountability	To make changes necessary for the agency to grow and evolve	*"why do it unless you're forced to?"*	To further QI efforts
Accreditation requirements	*No requirements*	*No requirements*	state association requires accreditation, anticipating the state to require accreditation	state contract	COA vs. state association accreditation
Agency's position in the field	enhance agency stature, credibility, prestige factor, clients' decision to choose agency	title of being the best	it was deserved to make them stand out	*"why do it unless you're forced to?"*	higher standards, recognition, and reputation

| Funding opportunities | Fight for survival, state budget | Funding for higher more qualified staff, funders requiring accreditation | (Direct care staff mentioned possible funding opportunities) | (Would have lost state contract, 50-70% of their business) | Funders will ask regarding accreditation status |

Aim 2: To explore agencies' experiences with the COA accreditation process. The study poses several questions toward this aim. What are the challenges, burdens, and costs they faced during the process? What are the unintended consequences of the accreditation process that may hinder quality service delivery? How did they benefit, and what did they learn and implement because of the accreditation process? In what organizational context is accreditation most effective at creating or ensuring quality? The answers to these questions will begin to reveal the impact of accreditation.

MERGED/SPECIAL FINDINGS	AGENCY #01	AGENCY #02	AGENCY #03	AGENCY #04	AGENCY #05
How the work was delegated	Led by QI Coordinator, along with Executive Team	Executive Director did most	Executive Director did most, New program director worked on PQI	Clinical Director did most	Led by QI Director, along with Program Director Committees
Length of process	Almost 2 years Applied before	More than 2 years	Almost 3 years	Approx. 1 ½ years	Approx. 1 year
Time consuming self-study	Most difficult part, intake stopped, had to continue other responsibilities 6 mos. extension for self study	Executive Director led, paper chasing her in her dreams, turnover, small agency, at least 3 days a week to COA, in early, out late	Executive Director led, difficult with staff turnover, had to work as direct staff at times	CD worked 12-17 hours a day, seven days a week, from home, tornado	Extra hours, staying late, coming in early, working weekends, working from home, rearranging schedule with clients
The site visit	2 reviewers for 2 ½ days Easiest part of the whole process Not in-depth, didn't confirm the self-study	2 reviewers for 3 days Peer reviewers were here to help, not to discover the worst of the worst	2 reviewers for 3 days We had a wonderful site visit Staff appreciated sharing with the peer reviewers	2 reviewers for 2 ½ days Helpful, it was fun COA would not allow rescheduling One reviewer was novice	2 reviewers (3rd couldn't make it) for almost 4 days That was fun, validating Meeting with reviewers not confidential with the

					door open
COA recommendations	Several recommendations on Pre-Commission Report (PCR) re: more evidence meeting minutes, more info re: restraints	1 deferral, PQI, which agency focused on fire drills and file reviews	2 deferrals, mostly with PQI, received technical assistance from COA	Only 2 recommendations on PCR: facility and vehicle maintenance checks	No PCR
COA standards	Making agency fit standards vs. vague and general Relevant and reasonable Agency responsible for checking the website	Relevant and more specific would have been more helpful Need to find additional resources to meet standards	Different interpretations from COA Did not know how to get guidance from COA Executive Director struggled to find the wording to answer the standards	Good, straightforward, should have been done, good reference point	Found they were already doing a lot what the standards asked
Balancing COA with other standards	HR and FIN standards, state over COA	--	--	In line with state requirements	Higher than state association accreditation standards
Contact with COA	Some mistakes in the standards NAs	AC was very available Changed from type of agency vs. state/region	Different Accreditation Coodinators No guidance from COA, but COA is not designed for that	Would have wanted more contact	QI attended training before deciding on COA

228

Learning COA	ED had worked at COA accredited agencies	Executive Director attended COA training Talked to others in the community	Talked to COA accredited agencies	Clinical Director attended COA training Executive Director learned about COA from coalition	Directors attended COA training Predisposed to COA

Aim 3: To identify mental health care workers' perceptions of how the accreditation process can improve mental health service delivery and outcomes. The study asks the question, what are the mechanisms and standards that may be leading to service improvements during the accreditation process? I aim to generate hypotheses regarding how accreditation can be used to impact quality of care in meaningful ways to improve consumer outcomes.

MERGED/SPECIAL FINDINGS/ COA STANDARD	AGENCY #01	AGENCY #02	AGENCY #03	AGENCY #04	AGENCY #05
Helped agency evolve and grow OR not a big impact from accreditation	To evolve from mom and pop operation, new perspectives to improve Documentation of policies and procedures	More formalized approach Characterize what we do	To have your business grow up, reexamine Documentation	Already providing quality services	Not a lot of change because they were already implemented
Reactions varied based on staff involvement, how work was delegated	Increased communication but some were critical of accreditation and its impact	Better teamwork, communication and morale	More bottom up staff involvement	More working as a team	More staff input for PQI, but also frustrated direct care staff, more work, decreased morale
Oversight	Keeps us on our toes	Might get a little slack	State association requirement	Keeps them vigilant	Using COA to answer to government
Administrative and Service Environment (ASE)		Fire drills Vehicle and driver's license verification		Emergency procedures Vehicle inspections	
Performance Quality Improvement (PQI)	Outcomes Meeting minutes Increased stakeholder involvement (client	File review Fire drills	PQI to PIC Consistent file reviews More data	More consistent meetings Program PQI goals	More monitoring More stakeholder involvement

	surveys)				
Human Resources (HR)	Used state standards Employee handbook			More organized personnel files	Evaluations for consultants
Behavior Support and Management (BSM)	More info regarding restraints				Restraint debriefings
Client Rights (CR)	Appeals process	Privacy addressed at intake, permission to release form		HIPAA more consistent	HIPAA more consistent and easier to understand
Training and Supervision (TS)	Helped new staff learn job	First aid training		More clinical trainings and more consistent accountable supervision	More consistent training due to documentation
Risk Prevention and Management (RPM)	Evidence of review, meeting minutes	Psych med training			
Governance (GOV)	Increased involvement, needed their approval Conflict of interest policy	More board involvement Conflict of interest policy	Realized need for more staff Top down approach to PQI not received well		Aware of need for board diversity
Financial Management (FIN)	Used state standards	More development efforts, found volunteer		More consistent meetings re: finances	
Service Standards	Better aftercare	More info at intake	New director and administrative assistant	More info at intake for assessment	Better aftercare More info for psych referral Less caseload More information

					about Indian Child Welfare Act