CONCEPT FOR A HOSPITAL ACCREDITATION SYSTEM IN GEORGIA

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I. Introduction

This paper evaluates the current status of readiness for beginning a hospital accreditation program in Georgia. The evaluation, conclusions, and recommendations are predicated upon three assumptions:

1. There is a commitment to pursue establishment of a hospital accreditation program for the Republic of Georgia.
2. There is a desire that the process of hospital accreditation be linked to health care financing, i.e., how hospital care is reimbursed.
3. Although health care accreditation should include all levels of care (primary care as well as secondary and tertiary care), the current CoReform project relating to accreditation is limited to hospitals.

At the present time, there is no hospital accreditation program in Georgia. Licensing and certification exist.

Licensing of hospitals, as currently understood and practiced, does not specifically address the facility itself, but only specific clinical activities within the hospital. Thus, the licensing requirements only define the parameters such as hygiene, technology and equipment, and qualifications of staff that the hospital must meet to be legally permitted to carry out that clinical activity. There are no licensure requirements that relate to the physical structure itself, not to governance or management. Licenses are granted for an indefinite period; there is no requirement for license renewal, and there is no precedent for revocation of a license.

Certification, as currently understood and practiced, is granted to individual doctors. No other health professionals require certification. Like licenses, certification is granted for an indefinite period, there is no requirement for periodic renewal. Apparently certification has been revoked only under egregious circumstances.

Accreditation of health care organizations is defined as an external assessment of the entire organization’s performance against a pre-determined set of standards that are objective and measurable to the extent possible. Unlike licensing, which tends to focus on the capability the organization may have to deliver health care services, accreditation standards focus attention on the quality and safety of the services. Licensing generally is not time limited. Accreditation, on the other hand, is time limited, and the organization must periodically be re-evaluated to ensure that it continues to meet the standards in order to maintain its accreditation status. Therefore, accreditation not only fosters, but requires, a process of continuous improvement.

Accreditation as a tool for improvement of health care systems and quality of services has a long history. From the 1950s until the early 1990s, accreditation
programs existed only in developed countries. The decade of the 1990s saw a rapid proliferation of programs not only in developed countries, but increasingly in developing countries. By 2004 nearly 60 countries either had, or were in the process of developing, national health care accreditation programs. This interest was prompted by the realization that successful accreditation programs had been a significant factor in improving health care systems and care provision, supporting rationalization of reimbursement mechanisms, enhancing public trust in the quality of care and in the institutions providing it, and reducing the variation in quality between different health care organizations.

However, there are numerous examples of failed attempts at establishing health care accreditation programs. Although accreditation is of undisputed value, there are certain factors that should first be examined to determine the readiness of an organization, be that a national or regional government, a NGO, or an individual health care facility, to implement an accreditation program with the expectation for its success.

The remainder of this paper is divided into two sections. The first section analyzes the current Georgian status against these factors. This analysis is based on my own observations and interviews and the previous evaluations done by the CoReform staff and by the Scandinavian Care project. For each factor, there is a judgment as to whether this factor positively or negatively affects readiness for accreditation. The second section offers specific concrete steps that should be taken and a proposed time frame for these actions.
II. Current Status

1. Is there an understanding of what accreditation means?

   1.1. Relation between: Licensure, Certification, Accreditation

(a) Is there a clear understanding of the differences?

Licensure, as currently understood in the Ministry of Labor, Health, and Social Affairs (MoLHSA) applies to clinical activities within health care facilities, and certification applies to individual doctors. At the present time, there is some misunderstanding surrounding the meaning of accreditation as differentiated from licensing or certification. At the hospital level, those who have at least heard the term accreditation view it as a potentially punitive process and do not evidence understanding of the fact that it is a quality improvement initiative. Perhaps of even greater importance is the fact that very recently an agency under the Ministry of Economics called the “Center for Accreditation” has been created. The head of this new entity has no health care background and was completely unaware of the concept or definition of accreditation in a health care setting. In the discussion with this new Center, the terms license and certification appeared to be used interchangeably.

**Negative:** Until there is an agreed upon definition of accreditation and how it differs from licensure, the goals as well as the process will be fragmented by differing opinions. Also, unless there is definitive action and pronouncements from the MoLHSA that accreditation is not intended to be punitive, resistance to participation at the hospital and the individual provider level will likely be significant.

2. Are there any current licensure and/or certification requirements?

   2.1. Licensure and/or certification requirements for health care facilities?

Licensure requirements for “activities” within health care facilities exist and have been in existence for some time. However, interestingly the license is apparently not granted to the entire facility or organization. Instead, there are separate licenses for each “activity” such as “General License for inpatient general surgery” and “Special License for inpatient general surgery of children” and “Special License for inpatient general surgery of adults”. The same holds true for certification of individual providers. **However, it has not been possible to clarify whether there are specific criteria on which either license or certification is granted. Thus far, it has only been clarified that a license requires an “organized environment,” and that this includes something about hygiene, technology and equipment, and qualification of staff.**
2.2. Licensure and/or certification requirements for individual health care providers?

Certification is granted to individual doctors (there are apparently no regulatory criteria for other health professionals). Like licensing, certification has no expiration. It has not been clarified whether there are specific criteria that must be met before granting a certificate to an individual doctor.

**Positive:** There is a basic concept that certain criteria must be met before being granted legal permission to care for patients. This concept can be transferred to criteria for accreditation.

2.3. Are there any requirements for re-licensure or re-certification?

(a) For individual providers?
(b) For health care facilities?

Currently and historically there is no requirement for re-licensure or re-certification. Both licenses and certificates remain valid indefinitely. There have been individual providers whose certificate has been revoked, but apparently only under egregious circumstances. Until the new Law on Licensing became effective in June 2005, there was no legal mechanism for revocation of a license. The law now permits this, but that provision has never been exercised.

**Negative:** The lack of any requirement, including criteria to be met, to renew a license or certificate leads to complacency and lack of any incentive to change the status quo. Thus the concept of periodic re-evaluation will be a new concept.

3. How does government and the private sector view their respective roles?

3.1. Does the government feel:

(a) Accreditation should be exclusively a government responsibility.
(b) Accreditation should be exclusively in the private sector.
(c) Accreditation should be a government/private sector “partnership.”

The new licensing law that became effective in the summer of 2005 mandates the creation of a State Uniform Accreditation Bureau. This has apparently led to the creation of the “Center for Accreditation” under the Ministry of Economics. However, the structure of this bureau, including membership, responsibilities, and authority has not been defined.
**Neutral to Negative:** Although there is now a legally authorized entity for accreditation, it is not clear what role it would play in hospital accreditation. If hospital accreditation comes under the Ministry of Economics, this factor will be negative, since the required health care expertise will not exist.

3.2. Does the private sector feel:
   - (a) Accreditation should be exclusively a government responsibility.
   - (b) Accreditation should be exclusively in the private sector.
   - (c) Accreditation should be a government/private sector "partnership."

Due to the lack of understanding of accreditation at the hospital and provider level, this factor cannot be evaluated. The options (b) and (c) should be considered at some future time, but the current reality is that there is no NGO with an infrastructure that would permit it to operate an accreditation program either alone or in partnership with the government.

**Neutral:** This does not seem to be a significant factor relating to the ability to start the process of developing an accreditation program since the final structure or political location of the agency that oversees the process does not preclude defining it functions.

4. What is the purpose/goal of accreditation?

4.1. Government view:
   - (a) Use as a tool to reduce the number of hospitals
   - (b) Rationalize payments/reimbursements/fund allocation
   - (c) Improve quality
   - (d) Increase public trust

Although it is difficult in Georgia to define a single “government view,” at the level of MoLHSA the above four goals seem, perhaps in the order written, to be a consensus.

**Positive:** Since the government is at least beginning to articulate the goals of an accreditation program, it allows a starting point for the development of a program.
4.2. Private Sector view:

As stated above, the lack of understanding of accreditation at the hospital and individual provider level precludes evaluation of this factor. However, it is doubtful that all hospitals in the private sector would agree with the first government, goal and perhaps only those already considered amongst the best would agree with the government’s second goal. The government’s first two goals will in all likelihood be viewed by hospitals and individual providers as punitive.

**Negative:** The lack of a consensus by all stakeholders will be a major obstacle and can be expected to lead to resistance by some hospitals and providers, particularly those who feel most threatened by periodic external evaluation that would support the government’s goal of reducing the number of hospitals.

5. Is there agreement on the scope of program?

- (a) Private facilities only
- (b) Government facilities only
- (c) All facilities
- (d) Hospitals only (if limited, why?)
- (e) Primary care facilities only (if limited, why?)
- (f) Both hospitals and primary care facilities
- (g) All services in the facility or only selected services?

There does seem to be a desire that accreditation encompass the entire spectrum of health care from primary care through secondary and tertiary care. However, at the present time there does not seem to be any meaningful structure to allow accreditation related projects being done in different sectors (primary care and hospitals) by different donors to be coordinated. For example, a British firm (OPM) is working on “standards” for primary care, the WHO is piloting a project in several hospitals on the development and use of “performance indicators,” and CoReform is tasked with developing a hospital accreditation program. Currently, no mechanism exists for coordination of these efforts.

**Positive to Neutral:** Listing this factor as positive is predicated on the assumption that a working group with membership drawn from all the stakeholders can be formulated and that this group include representatives from all the donor organizations that are playing any role in accreditation related activities.
Negative: If such coordination does not take place, hospital accreditation will have to occur in isolation. This will seriously impair the ability to link contracting for primary care services to the results of accreditation.

6. Has the organization discussed the concept of accreditation with its members or stakeholders?
   (a) Is there concurrence?
   (b) Is there resistance?

There is little evidence that the MoLHSA has had the opportunity for any meaningful dialogue with stakeholders to discuss the concept of accreditation. In fact, it is not clear whether the MoLHSA has identified what stakeholders that should be involved.

Negative: The apparent absence of discussions with all potential stakeholders is perhaps the most important deficiency that could doom or at best delay the start of a health care accreditation program. If a working group (see factor 5 above) can be established and a dialogue started, this factor in the near term could become neutral.

7. Is there leadership commitment?
   7.1. MoLHSA
   (a) Understands that process requires change
   (b) Has or can get the support of staff
   (c) Willingness to self-evaluate the organization’s functions
   (d) Willingness to commit resources/time when technical advisors are not present
   (e) Understands that accreditation is an ongoing process and not a one-time end-point
   (f) Willingness to allow external evaluation

At the present time the MoLHSA seems positively inclined toward all the sub-factors above except for factor 7.1.(d). It is perhaps likely, and certainly this occurs frequently in my experience, that in the absence of the continued presence of technical assistance such as CoReform, the initiatives of development of a reform program like accreditation get overtaken by the press of daily business. The financial and resource implications are discussed under Factor 12 below.
**Positive:** With the caveat that the results of the forthcoming election and/or any change in leadership might change priorities, this factor is positive.

7.2. Private Sector

(a) Has or can get support of staff  
(b) Willingness to self-evaluate the organization’s functions  
(c) Willingness to allow external evaluation

The WHO project on performance indicators seems to show that given the right structure and goal, when combined with credible leadership, it is possible to generate the support and participation of providers for sub-factors 7.2.(a) and (b). The evaluation of sub-factor 7.2.(c) will have to await a more clear definition of the goal of accreditation, who will oversee it, and who will be the external evaluators. This is critically linked to the private sector’s view that accreditation is intended to be a punitive process.

**Neutral to Positive:** This factor is listed as neutral rather than positive due to the inability to evaluate the willingness to accept external evaluation. Unless the MoLHSA takes positive steps to change this perception, this will remain a major impediment to successful implementation of an accreditation program.

8. Is there an understanding of the length of time required?

(a) Expects short-term (less than one year) results  
(b) Expects mid-term (1-2 years) results  
(c) Expects long-term (greater than 2 years) results

Notwithstanding the fact that there is not yet a clear understanding of what accreditation means, there does seem to be recognition that whatever it is cannot be accomplished as a short term project. However, the political reality is that approaching or following the fall 2006 elections pressure may develop to accelerate the process.

**Neutral:** This factor is neutral at the present time but may change. If the recognition that this is a long-term process remains, the factor is positive. If political pressure causes the process to be accelerated, the factor becomes negative.
9. Is there a stable organizational structure for the “long-haul”?

(a) How often does the leadership of the organization change?
(b) Is there an organizational structure (departments, divisions, committees) that continues despite leadership change?
(c) Is there an organizational structure/culture that allows development and implementation of long-term strategies?
(d) What is the planning process for the organization?
(e) Does the organization have clearly defined responsibilities and accountability?

In all likelihood, this factor cannot be assessed until after the fall 2006 elections (if then). However, if the legal entity, the State Uniform Accreditation Bureau, can be developed in the near term, it may provide the structure that might provide stability across changes in leadership positions in government.

Negative to Neutral: Until the “ownership” of the health care accreditation process is clarified, this factor is negative and may lead to conflicting goals and approaches. It will not preclude starting to build the framework for accreditation, but unless clarified, will have negative implications for long-term success.

10. Has there been an introduction to concept and practice of QI?

(a) Has the concept of QI been introduced?
(b) Have leaders been educated in the principles, tools and techniques of QI?
(c) Has QI actually been implemented?
(d) Are there any demonstrable results?

From my own observation and from the findings of Scandinavian Care, it seems that quality improvement concept and practice has been introduced in only two hospitals – M. Iashvili Childrens Hospital and Gudushauri Hospital. Although I have not visited all of them, the hospitals participating in the WHO performance indicator project seem to have the basic concepts of self-evaluation. It is also possible that the concept is present in isolated departments in other hospitals (such as the Neurosurgical Department at the Republican Hospital). The MoLHSA does not have any current plans to require a quality improvement process in all hospitals.

Negative: Unless there is some form of quality improvement monitoring at the level of health care facilities, the concept of self evaluation or external evaluation against measurable standards will be a foreign concept.
**Positive:** Since the concept of quality improvement has been introduced and implemented in only a few hospitals, primarily if not exclusively in those participating in the WHO performance indicator project, these hospitals should be included in the initial testing (piloting) of accreditation standards and should have representation on the working group.

11. Is there any experience with self-assessment?

(a) Has there been any organizational experience with self-evaluation?
(b) Voluntary or mandatory?
(c) Were there any specific criteria against which the organization evaluated itself?
(d) Were there any positive results/changes that resulted?

This is very well established in the M. Iashvili Childrens Hospital, and there were also examples provided by the Chief Doctor and Chief Nurse at the Gudushauri Hospital. Data collected by the participating hospitals in the WHO performance indicator project also demonstrate the ability to self-assess based on specific criteria. Responses at other hospitals indicated that the evaluation process was limited to evaluation of bad outcomes and focused primarily on the culpability of the provider. At the Ministerial level there are two committees (Quality Control and Maternal and Child Health) that have evaluated adverse events or outcomes, albeit only for the purpose of punishment. However, at least there is some experience with evaluation of the outcomes of care.

**Neutral to Positive:** Since there is experience with evaluation of poor outcomes and in a small group of hospitals experience with self-assessment of data, it should not be an overly difficult transition to evaluation of systems that might improve outcomes and reduce poor outcomes.

12. Is there an understanding of cost and willingness/ability to financially sustain the program after donor funds cease?

(a) With or without technical assistance has the organization developed a pro forma budget for an accreditation program?
(b) Has it developed any preliminary policy statements about future funding sources?

At the present time this work has not either begun or been discussed. Although this is not an immediate task, at some point in the intermediate term (at least two years before donor funding ceases) this becomes a critical factor. Failure to develop a financing scheme for support of an accreditation program is the single most common factor leading to the gradual atrophy and ultimate failure of the process.
**Neutral to Negative:** Listed as neutral only because it is early in the development process. However, if not concluded and approved at least one year prior to cessation of donor support, it will be not only a negative factor but a proverbial “show-stopper” and donor funds will have not created a sustainable program.

13. Are there available personnel who have been exposed to accreditation elsewhere?

(a) Have any personnel been exposed to accreditation?
(b) What is their attitude (positive or negative)?
(c) Are they in leadership positions?

The reality is that there are no personnel at almost any level who have actually been exposed to accreditation in the “real world.” The only individual who has relatively deep understanding of the concept is the Director of the M. Iashvili Children’s Central Hospital, Dr. Irakli Sasania.

**Negative:** The lack of practical exposure to the concepts and practices of accreditation is a significant impediment. Absent some practical exposure, the concept remains almost an academic discussion.

14. Are there incentives for participation in accreditation?

(a) Has the organization considered what incentives are needed?
(b) Positive for success or punitive for failure?
(c) Voluntary or mandatory participation?
(d) Financial?
(e) Other rewards?

As previously discussed under Factor 4 (Purpose and Goals), the goals of the program have not been clearly defined nor articulated to stakeholders. It does seem clear from the government’s perspective that the primary incentive is intended to be financial and that accreditation and reimbursement should be linked to a Darwinian concept of the “survival of the fittest,” which will ultimately reduce the over-capacity of hospitals. Unless there is the political will to mandate accreditation and sanctions for failure, financial or reimbursement incentives remains the only viable incentive. Even considering this goal/incentive, it is critical to portray this as a program that **rewards** good performance rather than one that punishes poor performance.

**Positive:** The government has clear and rational goals. The mechanisms of how to meet these goals remains to be determined.
III. Conclusions

Although at the present time there are many significant barriers to the successful implementation of a hospital accreditation program, none are insurmountable. If concrete steps are taken in the medium term (perhaps the next 6-7 months), the foundation will have been laid on which an accreditation program can be built.
IV. Recommendations

1. Develop a small working group for hospital accreditation.

A small (perhaps 8-10 individuals) group representing a broad spectrum of hospital accreditation stakeholders should quickly (within no more than one month) be formed. The membership should include appropriate MoLHSA representatives, hospital representatives, representatives of other donor agencies such as WHO and OPM, representatives from SUSIF, and potentially from the private health insurance sector. It is of vital importance that this group be led by someone highly respected and knowledgeable of the concepts of accreditation and organizational self-assessment.

This group should focus on three areas:

(a) With technical assistance, recommend the functions, including the structure, organization, roles, responsibilities, and authority of an accreditation agency.
(b) With technical assistance, start the process of creating an initial draft of hospital accreditation standards.
(c) With technical assistance, assist in the testing of the accreditation standards and process in a small group of hospitals.

This group should also meet periodically with the information systems working group.

2. Develop an agreed upon definition of health care accreditation.

It is critical that a clear definition of accreditation be developed, a consensus on the meaning be obtained, and that the definition be widely communicated to all stakeholders. The definition must draw a clear distinction between licensure and accreditation. The following are suggested definition of each.

Licensure: is the legal granting of permission to carry out health care related activities based on criteria relating to basic hygiene, technology and equipment, and qualifications of staff. A license testifies to the fact that the holder of the license has the ability to provide care. A license has no expiration but may be revoked.

Accreditation: is granted based on the entire hospital’s ability to demonstrate to external evaluators its ability to meet pre-established standards that to the maximum extent possible are objective and measurable. Accreditation standards build on the foundation of ability to provide care by requiring the management and clinical staff to evaluate and
improve structure, processes, and outcomes of care. Accreditation requires continuous improvement and is granted only for a defined time period. The organization must successfully undergo periodic re-evaluation to retain its accredited status.

3. **Define and publicize the goals of health care accreditation.**

   This must begin to dispel the belief held at many hospitals, and perhaps still by some within the MoLHSA, that accreditation is another tool for justifying punishment. The goals could be stated as follows:

   - Provide recognition and reward to those hospitals that demonstrate they are evaluating and improving the quality and safety of their care.
   - Allow future financial rewards to those who succeed in becoming accredited.
   - Continuously improve the quality of health care and services.
   - Enhance public confidence in their health care.
   - Improve national pride in the health care system.

4. **Draft Terms of Reference for a health care accreditation agency**

5. **Draft an initial set of hospital accreditation standards.**

6. **Provide training to the working group.**

7. **Draft an accreditation survey manual, including survey process and scoring guide**

8. **Provide initial didactic training to hospital accreditation surveyors.**

9. **Select a small number of hospitals to serve as pilots to test the validity of the draft hospital standards.**

   a. **Draft criteria for selection.**

   This does not have to be done until perhaps late spring to early summer. However, the participating hospitals should be selected no later than July 2006. For logistic as well as project financial management reasons, there should be no more than 5-6 hospitals. In my experience, when standards and accreditation processes are piloted in a large number of hospitals, the effort rapidly overwhelms the resources. The hospitals should be selected according to agreed upon criteria and, to the maximum extent possible, not on “political” considerations. The selected hospitals should represent a general spectrum of those that could reasonably be expected to participate,
i.e., small geographically isolated hospitals would not be included. Consideration should be given to including those that are already participating in the WHO performance indicator project. It will be important that there is some geographic dispersion of the test hospitals and all should not be in Tbilisi.

10. Begin the process of establishing an accreditation agency.

11. Each test hospital establishes an accreditation preparation committee or group.

   Each hospital should have at least one member of the overall working group who will have been trained and can serve as a liaison and resource person.

12. Each hospital conducts a self-evaluation against the draft standards and creates an action plan.

13. Technical assistance visit to validate the results of the self-evaluation and the action plan.

14. First “mock” survey conducted by technical experts at each test hospital with Georgian surveyors as observers.

15. Second “mock” survey by technical experts with Georgian surveyors starting to participate.

16. “Mock” survey done by Georgian surveyors with technical experts as mentors.
Appendix 1: Description of a National Health Care Accreditation Agency

As is true in all countries, if health care accreditation is to become a national program, enabling legislation or regulation is required; particularly if there is an expectation that governmental purchase of health care will be dependent on the accreditation status of a health care facility. Such legislation or regulation needs to give recognition to the unique aspects of health care accreditation as opposed to regulation of other industries or endeavors such as education.

The structure of a health care accreditation program consists of three organizational entities:

(a) An Accreditation Agency as the main oversight body. This is the Board of Directors.
(b) An Accreditation Management Office responsible for the day-to-day operation and coordination of the program
(c) Team of Surveyors

1. Health Care Accreditation Agency

1.1. Models

There are four general models of an accreditation agency:

(a) Purely governmental.
(b) Purely private, but sanctioned or recognized by the government.
(c) Independent with both government and non-government participation (quasi-governmental agency but with independence granted by legislation or regulation).

Although not a specific model for an accreditation agency, an alternative (as in the United States) is for the government to grant “deemed” status to those facilities that are accredited. This means that an accredited facility (for as long as it retains its accreditation) is deemed by the government to have met all the legal requirements. For such a model to work requires that the accreditation standards incorporate at least the basic substance of the governmental requirements. This concept will work with either model 2 or 3.

The most common model is the third; an independent agency with both governmental and non-governmental representation. In the long-term, this model works best, since broad representation ensures that all stakeholders feel a sense of ownership and it is not subject to frequent change due to political events or elections.
1.2. Structure and Membership

The agency must have a Board of Directors. Membership on the Board of Directors should be broadly based, and the membership distributed such that no single entity dominates. Members should serve for finite and defined terms. It may be preferable to have the membership based on position (ex officio) rather than by name. Examples might include:

- Government health care agency representation (MoLHSA)
- Government non-health care agency representation (SUSIF)
- Regional government representation
- Other government agency representation (Planning department, finance department, police, military, etc.)
- Non-government health care representation (hospitals and PHC directors)
- Non-government professional organizations (physician associations, nurse associations, other professional associations such as pharmacists)
- Lay public representation (religious leader, non-health care professional societies)
- Health care insurance company representation

The Board of Directors could have the following organizational structure:

1. Chairperson
2. Secretary
3. Executive Committee
4. Subcommittees such as:
   - Standards Development/Revision Subcommittee: judge, approve, reject, or modify suggested changes in standards by the accreditation management office.
   - Survey Process Subcommittee: review the results of survey and surveyors performance. Recommend modifications to the process as needed based on experience.
   - Accreditation Decision Subcommittee: approve, modify, or reject recommendations of the accreditation management office about granting or denial of accreditation to a health care facility.
   - Budget/Finance Subcommittee: approve budget, fees and other financial fiduciary responsibilities. This subcommittee could also assume responsibility for long-range strategic planning.
1.3. Responsibilities and Authorities

The main responsibility of the Health Care Accreditation Agency is to oversee all health care accreditation programs and ensure the integrity and credibility of the accreditation process. To accomplish this it should have the final authority on:

(a) Final accreditation decisions and final authority to grant or deny accreditation to a health care facility.
(b) Approval of new or modified standards.
(c) Official interpretation of standards.
(d) Scoring methodology.
(e) Oversight of the Accreditation Management Office.
(f) Appoint/approve senior manager of Accreditation Management Office.
(g) Develop/approve and oversee management of a budget.
(h) Provide liaison with other agencies (finance, insurance, planning, etc.) on issues affecting health care accreditation.
(i) Coordinate with Parliamentary Committees on any legislative matters affecting health care accreditation.

2. Health care Accreditation Management Office

Since the Board of the Health care Accreditation Agency itself may not have the technical skill or professional knowledge to accomplish all these responsibilities, it should establish a formal Accreditation Management Office. This office should have a full-time Director or Senior Manager reporting to the Board and a support staff sufficient to fulfill the following functions:

(a) Provide administrative support to the Board.
(b) Manage the daily operations of the accreditation program.
(c) Provide ongoing review of standards and proposed updating when needed.
(d) Ensure quality control of survey reports. This involves reviewing the draft reports submitted by the survey team to ensure that they are complete and that all standards scored by the survey team as not fully met have adequate documented evidence to support this conclusion.
(e) Make recommendations to the Board about the proposed accreditation decision for surveyed organizations.
(f) Formulate official interpretation of standards for Board approval in response to questions from surveyors or health care facilities.
(g) Provide initial training to surveyors and recommend to the Board those that are qualified to be certified as fully qualified.
(h) Provide ongoing training to surveyors.
(i) Process applications for surveys.
(j) Schedule surveys and determine the duration.
(k) Recommend to the Board the fees for accreditation surveys, training courses, and publications.
(l) Annually provide to the Board a proposed budget.
(m) Provide logistic support (travel and accommodations) to survey teams.
(n) Provide and/or support training courses, including the preparation of printed materials for staff of health care facilities to learn about the standards and the accreditation process.
(o) Prepare, publish, and update accreditation tools (survey report format)
(p) Manage budget.

3. Surveyor Team

The survey is the key step in the accreditation program. It is an organized and structured process to identify strengths and weaknesses of a health care facility. The survey process consists of a site visit to the facility conducted by a team of experts trained in the use of the accreditation survey instrument and tools. In addition to evaluating compliance with national standards, surveys are useful venues for exchanging skills and expertise between the survey team and facility staff.

To this end, perhaps the most critical factor in making the accreditation program credible is the quality and integrity of the surveyors. To ensure a highly qualified group of surveyors, the program should have the following:

(a) Selection criteria for “candidate surveyors”,
(b) A training curriculum for surveyors, and
(c) A formal process for certification. Each of these is discussed below.

3.1. Selection Criteria

To be selected as a candidate for training as a surveyor, the individual should meet at least the following criteria:

(a) The individual should be a volunteer with interest in and enthusiastic support of the accreditation process. Surveying should not just be a requirement of a job.
(b) The individual must have credible experience, such as at least 10 years of experience working in a hospital or primary care setting or
both. If surveyors do not have actual “hands-on” experience, or it was in the far distant past, it becomes very difficult for them to relate to the “real world” of health care.

(c) Must have good interpersonal and interviewing skills.
(d) Must have demonstrated ability to be an effective teacher. A surveyor is not just an inspector. They must be able to teach how to meet the standards and effectively gain the confidence of the hospital’s staff.
(e) Survey teams should have membership from more than one health care sector, with the majority being drawn from a different sector than the facility being surveyed.
(f) Surveyors should represent different specialties and sectors including physicians nurses and administrators.
(g) In addition to these personal attributes, the selection of “candidate surveyors” should ensure representation from all health care sectors (Government, Academic, Private, Hospital, and Primary Care).

3.2. Training of Surveyors

To ensure accountability of the program, each “candidate surveyor” should go through the following formal training steps:

(a) Attendance at a formal didactic course on the standards, the survey process, the surveyor guide, and the scoring methodology.
(b) Observation of at least one practice survey conducted by experienced surveyors.
(c) Conduct at least one (or more if needed) practice survey under the observation and tutoring of experienced surveyors.

Evaluation of their practical survey skills is based on evaluation of the following factors:

(a) Ability to work cooperatively in a group situation.
(b) Ability to actively participate.
(c) Ability to listen without interrupting
(d) Ability to convey a positive and helpful attitude.
(e) Knowledge and understanding of standards, survey process, and scoring rules.
(f) Interviewing skills
(g) Correct interpretation of standards
(h) Ability to teach.
3.3. Certification Process of Surveyors

To receive certification from the Health Care Accreditation Agency as a qualified surveyor, the following steps must be successfully completed:

(a) Successfully complete steps 1 – 3. above of the training curriculum.
(b) Successfully pass a written test on the standards and the survey process. It may be possible for highly motivated individuals who do intense self-study to meet this criterion without attending a formal didactic course required by step 1.
(c) Have the endorsement and recommendation of the supervising experienced surveyor.
(d) One final evaluation survey
(e) Have final approval of the National Accreditation Board.

The surveyors recommended for certification can be classified into three categories. At the top are those qualified not only as surveyors, but also as qualified trainers for future surveyors. The second category are those qualified to be surveyors, but not trainers. The third category are those who are qualified only to assist health care facilities prepare for accreditation, but will not conduct actual accreditation surveys themselves. With experience, any surveyor may move up to a higher category.