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QAP Editorial

Using Accreditation to Improve Quality

David Nicholas, MD, MPH

Director, Quality Assurance Project

A GROWING interest and expansion in accreditation programs has occurred worldwide during the past decade as demands for improved quality have increased and as a means to qualify providers for payment under new health reform models or to otherwise regulate providers. Under its scope of work, QAP has been exploring the role of accreditation in improving quality in developing countries and assisting these countries in determining whether to develop appropriate accreditation programs.

The concept of accreditation evolved during this century from an approach involving simple, voluntary programs that applied a few basic standards to an evaluation process that, when possible, applies evidence-based standards to determine the capability of large, complex health care organizations to deliver quality care. In the last two decades new, less formal accreditation programs that focus on encouraging health care organizations to provide good, client-centered care have also arisen, such as UNICEF's Baby Friendly program, the Gold Star Family Planning program in Egypt, the Proquali Reproductive Health program in Brazil and the emerging Adolescent Friendly Clinic programs in Jamaica and South Africa. Thus, the field of accreditation is evolving rapidly, presenting many interesting and sometimes difficult issues to consider.

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Just as the health community believes that medicine should be evidence-based, so, too, should the choice of QA activities. Thus, the question might be raised as to whether scientific evidence indicates that accreditation improves patient outcomes. Certainly, if the standards used for accreditation were evidence-based—that is, because studies have demonstrated that compliance with standards improves outcomes—it would seem logical that accreditation would improve outcomes. However, health care organizations may only comply with standards at the time of the accreditation evaluation (survey) and not at other times. In such cases, outcomes would not change. In an unprecedented study of the international application of accreditation standards, QAP is examining the effect of accreditation on outcomes in Zambia and South Africa.

Other important questions must be answered by developing countries that are considering accreditation:

- What sectors of the health system should be accredited—hospitals, ambulatory and primary care facilities, or both?
- Should both public and private sectors be included?
- To what extent should community representatives participate on accreditation boards or survey teams?
- Should the results of accreditation surveys be published and open to the public?
- Should the accrediting bodies be governmental or nongovernmental organizations?
- Should accreditation be mandatory or voluntary? If it were made mandatory, how would it differ from licensing?



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- What should be the strength of the evidence required to qualify a standard to be used for accreditation? Should the accreditation be based on outcomes, compliance with standards, or both?
- Should accreditation be linked to data from the routine monitoring system and not just external evaluations?
- Should accreditation surveys be scheduled or “surprise visits” or both?
- Should accreditation be primarily a facilitative, coaching encounter to help the organizations meet the standards?
- What should be the relationship between ongoing organizational self-assessment and the external assessment?
- What consequences should ensue for an organization that fails accreditation, especially if it is located in an area where it may be the only available health care provider?

Based on past experience, accreditation would seem to offer added value to health care systems.



- Should accrediting bodies be accredited to ensure compliance with accepted standards for accrediting and certifying bodies? Who should pay for the accreditation process?
- Finally, is accreditation cost-effective compared with other quality improvement approaches, and is it an “appropriate technology” for developing countries?

QAP is conducting research in an effort to answer these questions. QAP is also helping to sponsor

international conferences where experts and interested countries can reach consensus on these issues and find ways to assist developing countries resolve these questions. Based on past experience, accreditation would

seem to offer added value to health care systems. However, it will have to be proven cost-effective and adaptable to many different environments.



Improving Health Services Delivery with Accreditation, Licensure, and Certification¹

Donna Vincent Roa, PhD, Director of Communication and Associate Project Director, Quality Assurance Project

Anne Rooney, RN, MS, MPH, Executive Director Consulting Services for Joint Commission Resources, Inc.

HEALTH care managers and policy makers throughout the world are adopting quality approaches, methods, and tools to improve operations, create more efficient care processes, reduce work and inappropriate use of scarce resources, improve staff performance and oversight, and enhance patient and staff education. Though most agree that the ongoing evaluation of these kinds of improvements is imperative, less agreement exists on which evaluation approach can best meet the expectations of relevant stakeholders: the organization, regulatory agencies, senior public health officials, and patients.

This article presents a brief overview and history of standards-based quality evaluation and compares accreditation, licensure, and certification (Table 1) —three approaches that can provide quality and performance information needed by decision makers to:

- maintain and improve quality
- ensure public safety
- provide legal recognition to qualified health professionals
- verify that design or maintenance specifications are met

A Standards-Based Approach to Quality Evaluation

In 1917, the American College of Surgeons established a set of minimum standards for hospitals. Seen as the first standards-based external evaluation mechanism and as somewhat controversial at the time, these minimum standards encouraged a process of professional peer review based on the outcomes of care, an approach that is still being used today.

In 1951, the American College of Surgeons joined with several other professional associations to form the Joint Commission on Accreditation of Hospitals, the first formal health care accreditation program. Thirty years later, this voluntary accrediting body changed its name to the Joint Commission on Accreditation of Healthcare Organizations to more accurately reflect its broader scope of health services evaluation. In addition to hospitals, the body evaluated long-term care facilities, home health agencies, hospices, clinics, pharmacies, managed care organizations, and health care networks—more than 17,000 accredited health care organizations in the United States.²

¹ This article is based on the *Quality Assurance Project* publication: *Licensure, Accreditation, and Certification: Approaches to Health Services Quality* by Anne Rooney and Paul R. van Ostenberg. For copies of this document, write to qapdissem@urc-chs.com or call 301-941-8532.

² Smaller accrediting bodies focus on specific areas of accreditation (e.g., the College of American Pathology accredits clinical laboratories).



Table 1

Definitions of Accreditation, Licensure, and Certification

Process	Issuing Organization	Object of Evaluation	Components/Requirements	Standards
Accreditation (voluntary)	Recognized body, usually an NGO	Organization	Compliance with published standards, on-site evaluation; compliance not required by law and/or regulations	Set at a maximum achievable level to stimulate improvement over time
Licensure (mandatory)	Governmental authority	Individual	Regulations to ensure minimum standards, exam, or proof of education/competence	Set at a minimum level to ensure an environment with minimum risk to health and safety
		Organization	Regulations to ensure minimum standards, on-site inspection	
Certification (voluntary)	Authorized body, either government or NGO	Individual	Evaluation of predetermined requirements, additional education/training, demonstrated competence in specialty area	Set by national professional or speciality boards
		Organization or component	Demonstration that the organization has additional services, technology, or capacity	Industry standards (e.g., ISO 9000 standards) evaluate conformance to design specifications

Accreditation Programs and Key Features

Canada, Australia, the United Kingdom, and New Zealand are among the countries that have well-established hospital accreditation programs. Table 2 provides an overview of these and other existing hospital accreditation programs around the world and a comparison of their key features including types of standards, number of accredited hospitals, whether or not the body developed indicators, funding sources, and definition of scope.

Of the 21 hospital accreditation organizations shown in Table 2, about one third develop structure, process, and outcome standards. Most of the remaining two-thirds set structure and process standards. A few of the organizations set only process and outcome standards.

A large majority of the organizations rely on survey fees for financial support. Other sources of

funding include: member fees, publications, education programs, grants, consulting fees, and government, to name a few. Nearly three of four organizations limit their evaluation scope (e.g., hospitals, rehabilitation services, community hospitals, medical specialists, teaching hospitals, nursing, and rehabilitation and medical care hospitals).

Health Care Quality Evaluation Approaches

The three primary approaches for evaluating health care quality—accreditation, licensure, and certification—use standards to determine the level of quality achieved by an individual or organization. Selecting the right approach or combination of approaches requires a careful analysis and prioritization of user needs. The most effective system, even with its limitations, can generate objective quality data to:



- support comparisons of performance between the public and private health sectors and more appropriate government oversight of the health sector
- shape health care services delivery in new settings by monitoring access, quality, and risk
- demonstrate whether a predetermined rate of beneficiary coverage for preventive services is being achieved
- ensure efficient use and allocation of limited health care resources
- identify and create centers of excellence (e.g., those facilities that can provide greater volume of services, greater efficiency, and lower per case costs)
- integrate structures and services of several organizations to improve coordination and efficiency of care and reduce administrative costs

Accreditation

Unlike licensure, which focuses on adherence to minimal standards intended to assure public safety, accreditation

focuses on continuous improvement strategies, achievement of optimal quality standards, and ongoing education and consultation. Effective accreditation programs have well-defined missions; pre-determined infrastructure and authority for the program; participation from health professionals in standards development and interpretation; and relevant, objective, and measurable standards. A strong accreditation program:

- encourages professionals to continuously seek to improve quality despite resource limitations
- provides sustained management of field operations (e.g., selection and training of peer reviewers, supervision and ongoing education of surveyors, etc.)
- ensures a fair, valid, and credible process
- establishes an accreditation database of information to determine compliance, pinpoint problem areas, or highlight opportunities for improvement

Accreditation standards, which are usually developed by a consensus of health care experts, reflect

state-of-the-art thinking about health care quality, advances in technology and treatments, and changes in health policy. Organized by key organizational processes or functions (e.g., patient assessment or human resource management) or by department (e.g., pharmacy services and nursing services), accreditation standards offer health care organizations a systematic way of organizing operations

The threshold for determining whether or not the health care organization is accredited must be based on pre-determined rules that are consistently applied in order for an accreditation program to maintain its credibility and customer confidence.

for optimal efficiency and effectiveness—a key tenet of quality assurance. Most health care accrediting bodies use a variety of evaluation strategies to determine compliance, performance, and quality of care:

- document and record reviews
- interviews



- observations
- achievement evaluations
- facility inspections

Evaluation teams comprised of peer reviewers or surveyors visit facilities, either announced or unannounced, to evaluate compliance with accreditation standards. Announced evaluations guarantee greater participation in the process, although this allows organizations time to enhance surface appearances, potentially making it more difficult for a team to determine usual practices and operations. Once the evaluation is completed, an accreditation designation—accreditation with commendation or accreditation with recommendations, for example—is given.

For an accreditation program to flourish, decision makers should consider the question of sustainability or financial viability and address funding sources for each phase of the program. Financial incentives, for example, can help to maintain the program, reward organizations' superior performance, and stimulate professional commitment.

Licensure

Established to protect basic public health and safety, licensure standards address the minimum legal requirements or qualifications health care profes-

sionals and organizations need to operate. They also guarantee appropriate adoption of new medical practices and provide a framework to accommodate amendments to existing practices.

Licensure programs for individuals involve examination of credentials, inspection of educational programs, testing of professional qualifications, reciprocal granting of licenses to applicants of other

countries, issuance of regulations establishing professional standards of practice, and investigation of charges of violations of standards.

In the United States, the Federation of State Medical Boards and its member boards use *A Guide to the Essentials of a Modern Medical Practice Act*, a document containing concepts and policy statements for establishing or improving systems of physician regulation or medical practice acts. Topic areas include:

- examinations
- requirements for full licensure
- granting of temporary and special licensure
- disciplinary action against licensees
- procedures for handling impaired or incompetent practitioners
- unlawful practice of medicine
- periodic renewal of registration

Many countries have a licensure system. However, due to lack of funding and poor oversight, system inspectors typically focus on the individual's or organization's compliance with the minimum regulations and do not consult, educate, or share best practices on ways to meet standards or improve procedures and processes.





Table 2

Comparison of Existing Hospital Accreditation Organizations

Country	Accrediting Body	Types of Standards	Number of Accredited Hospitals	Developed Indicators	Funding Source	Limited Scope?
United States	Joint Commission on Accreditation of Healthcare Organizations	Structure, processes, and outcomes	5,155	Yes	Survey fees, publications, education programs, and consulting	No
United States	American Osteopathic Association	Structure, processes, and outcomes	400	No	Survey fees	Yes, hospitals
United States	Commission of Accreditation of Rehabilitation Facilities	Structure, processes, and outcomes	700-800	Proposed	Survey fees, publications, and education	Yes, rehabilitation services
Canada	Canadian Council on Health Services Accreditation	Processes and outcomes	502 (1996)	Proposed for 2000	Member fees and survey fees	No
United Kingdom	Health Services Accreditation	Structure, processes, and outcomes	Unknown	Yes	Survey fees or grants	Yes, hospital departments
United Kingdom	Kings Fund Organizational Audit	Structure and processes	79 (1994)	No	Survey fees and publications	Yes, hospitals
United Kingdom	Southwestern Hospital Accreditation Program	Structure and processes	67 (1994)	No	Grants, survey fees, consulting, and publications	Yes, community hospitals
Netherlands	National Organization for Quality Assurance in Hospitals	Structure and processes				Yes, medical specialists
Netherlands	Netherlands Institute voor Accreditation van Ziekenhuizen	Structure and processes	18	No	Survey fees	Yes, hospitals
Australia	Australian Council on Healthcare Standards	Structure and processes	203 (1994)	Yes	Survey fees, publications, and education	No



(continued)

Table 2

Comparison of Existing Hospital Accreditation Organizations

Country	Accrediting Body	Types of Standards	Number of Accredited Hospitals	Developed Indicators	Funding Source	Limited Scope?
New Zealand	Health Accreditation Programme for New Zealand	Structure and processes	115 (1997, all services)	Proposed	Member fee (1998)	No
Taiwan	Ministry of Health	Structure, processes, and outcomes	525	Yes	Government	Yes, hospitals
Japan	Council for Quality Health Care		79			Yes, community hospitals
Korea	Joint Commission on Accreditation of Hospitals	Structure and processes	131	Yes	Survey fees	Yes, teaching hospitals
Korea	Hospital Performance Evaluation Program	Processes and outcomes	96			Yes, hospitals
China	Hospital Grade Appraisal Committee, HB		1,086 (1991)			Yes, hospitals and teaching hospitals
South Africa	Council for Health Service Accreditation of South Africa	Structure, processes, and outcomes	40	Proposed	Survey fees	No
Czech Republic	Joint Committee on Accreditation	Structure, processes, and outcomes	13	Yes	Survey fees	Yes, hospitals
Kyrgyzstan	Ministry of Health	Structure, processes, and outcomes		No	Survey fees, board member organization support, other	Yes, hospitals
Lithuania	State Accreditation Services by Ministry of Health	Structure and processes	53	No	Ministry of Health and survey fees	Yes, nursing, rehabilitation, and medical care hospitals



Hospitals and health care facilities must be licensed to provide care or services to patients. Governments or regulatory authorities grant licenses when facilities meet defined levels of quality or provide certain services (e.g., surgery, radiology testing, round-the-clock nursing care, pharmacy services, and laboratory services). In some jurisdictions within the United States, the hospital or health center also may be required to demonstrate a need for the services within the local community before receiving a license to operate.

Certification

Distinguished from accreditation by its application to both individuals and organizations, certification involves a recognized authority or board granting recognition to individuals who have demonstrated specialized knowledge and skill and to organizations that have the ability to practice in a certain area or speciality.

In the United States, the American Board of Medical Specialties (ABMS) and the American Medical Association Council on Medical Education (AMA/CME) review and approve medical speciality boards and work to standardize their approaches. The two organizations also maintain a rigorous process of application and review for new boards in emerging medical specialties (e.g., the American Board of Medical Genetics).

Most medical speciality boards require re-certification at periodic intervals, usually seven to 10 years for an evaluation of continuing experience, skills, proficiency, performance, and clinical outcomes. If an individual does not meet the standards, certification can be withdrawn. Verification of performance, however, does not include a review of actual care processes or patient outcomes.

In recent years, professional organizations, such as the American Medical Association, through its American Medical Accreditation Program, have started to evaluate individuals within their work environment. This voluntary, standards-based evaluation mechanism complements the formal medical speciality certification. Reviewers conduct an evaluation of credentials and qualifications, actual practice conditions, environment of care, clinical processes, and patient outcomes.

For organizations, lack of proper certification can affect funding, reimbursement for health services, and legal recognition. Certification distinguishes organizations as capable of practicing or delivering services in a speciality area.

Summary

The heightened interest in the quality evaluation of health services and the growing expectation for quality services from communities and consumers in developed and developing countries alike have created a unique climate for health care managers, policy makers, and senior decision makers. They must rely on strategies that can affect the daily operations of health care organizations and ensure better service delivery. Accreditation, licensure, and certification yield the objective data they need to do just that. Each approach, tailored appropriately, can lead to increasing the availability and quality of health care services, decreasing the cost to patients, and strengthening the health care delivery systems.





Joint Commission International Accreditation

Building on its experience in accrediting health care organizations in the United States, the Joint Commission on Accreditation of Healthcare Organizations initiated the development of an international accreditation program in 1998. An international task force representing all regions of the world was convened to provide input into the standards development process. The task force distributed the draft standards to international reviewers to determine their applicability to an international health care setting; they were then pilot-tested in several hospitals in Latin America, Europe, and the Middle East.

Full implementation of the Joint Commission International Accreditation (JCIA) program took place in late 1999. Accreditation may be requested either by an individual hospital or by an accrediting body in another country that may wish to partner with JCIA to offer a joint accreditation, using a full or modified set of JCIA standards.

The final standards represent the important processes and functions of any hospital and are flexible enough to be adapted to meet the needs of a particular country with unique cultural or health care characteristics. The JCIA standards, organized according to either patient

care functions or management functions, represent the following important hospital functions or processes:

Patient-Focused Standards

- Access to care and continuity of care
- Patient and family rights
- Assessment of patients
- Care of patients
- Patient and family education

Health Care Organization Management Standards

- Quality management and improvement
- Governance, leadership, and direction
- Facility management and safety
- Staff qualifications and education
- Management of information
- Prevention and control of infections

Further information about JCIA and the international hospital standards can be obtained by contacting JCIA, One Lincoln Centre, Suite 1340, Oakbrook Terrace, IL 60181. Phone: 1-630-268-7400.



Jointly Sponsored Regional Conference Held on Quality Improvement

*Joanne Ashton, RN, MN
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FIFTY-TWO representatives from 19 Latin American countries participated in a regional conference in Bogota, Colombia in May 1999 organized by the Quality Assurance Project (QAP) and the Pan-American Health Organization (PAHO) to explore the differences between accreditation, licensure, and certification in the context of quality improvement. Representatives from the various Latin American Ministries of Health, the Association of Latin American Hospitals, medical and nursing associations, the World Bank, the Inter-American Development Bank, QAP, and its partner Joint Commission Resources (JCR) discussed options, strategies, and tools for accreditation, licensure, and certification, in addition to identifying the related functions of government, financial entities, and health care providers in implementing these processes. The group also developed conclusions and recommendations regarding the application of these quality improvement approaches within Latin America.

Introductory Presentations

Dr. Daniel López Acuna (PAHO) opened the conference by proposing that quality be defined in terms of satisfaction of clients' needs and expectations through improving health care processes. He suggested that quality should be the primary objective of the political health care sector. Dr. Acuna indicated that the main challenges that face quality improvement programs include the coordination of services and resources, continuous professional education and certification, articulation of a health technology evaluation process, and evidenced-based medicine.

Dr. Jorge Hermida (QAP) discussed the importance of total quality management, starting with the premise that all elements of the management process should be oriented toward quality as defined by the client. A quality program was defined in terms of quality control, quality improvement, and quality design.

Dr. Hermida reviewed various needs of clients (both internal and external) that affect their perception of quality, including interpersonal relationships, access to services, comfort measures, technical competence, effectiveness, and efficiency. Accreditation, licensure, and certification were identified as methods of generating and measuring evidence to support the quality assurance process.

Accreditation

Accreditation models from Canada and the United States were presented. Dr. Elma Heideman (CCHSA) described the Canadian experience and emphasized the importance of a philosophy of patient-centered care, quality improvement, and community health. Competency standards, information systems, and a high degree of leadership were identified as essential ingredients for a successful accreditation program. The Canadian accreditation model is oriented toward the fulfillment of indicators and standards to reduce risks. Accreditation reports are submitted to the assessed organizations, as well as to authorities at the provincial and national levels. Areas summarized include risk management, strengths, weaknesses, and recommendations. The focus of the Canadian accreditation program is on establishing standards of



accreditation, assisting organizations to monitor their achievements, and accrediting the institutions.

Mr. James Janeski (JCR) and Dr. Paul van Ostenberg (JCR) presented the process of accreditation used by the Joint Commission of Accreditation of Hospitals in the United States. They stressed that the development of standards must be a participative process among surveyors and health professionals and that surveyors demonstrating knowledge and diplomacy should perform surveys. They also stressed that standards established through the accreditation process require time to implement and institutional preparation. Accreditation is not a final goal, but a dynamic process that is part of generating a culture of quality. The granting of accreditation differentiates an institution, thus placing it in a better position to deliver quality health services.

Certification

Dr. William Jessee (AMA) outlined the key elements of professional certification in the United States. First, certification is not governmental; the executing agency is usually a private organization. Physicians, nurses, and other health care professionals seek certification as a means of establishing credibility in a specialty such as critical care. Thus, certification is voluntary and outside the formal education and licensure processes. Typically, certification involves taking a specialty examination for which the candidate covers the cost. Dr. Jessee described some weaknesses of certification (e.g., examinations measure knowledge but not the technical competence of a practitioner). Once a practitioner has been certified, the focus may be on the “pedigree” rather than on professional accomplishments. Also, intervals between recertifications are long.

Dr. Jessee also described a new program of physician accreditation initiated by the American

Featured Presentations

- Dr. Daniel López Acuna, Pan American Health Organization, *General Framework on Quality Assurance and Quality Improvement Programs in the Region of the Americas*
- Dr. Jorge Hermida, Quality Assurance Project, *Principles and Framework of Quality Assurance*
- Dr. Elma Heideman, CCHSA, *CCA Program in Canada*
- Mr. James Janeski and Dr. Paul van Ostenberg, Joint Commission Resources, *General Vision on Accreditation*
- Dr. William Jessee, American Medical Association, *Certification*
- Dr. Joelle Lescop, Medical College of Quebec, *Licensure in Canada*

Medical Association. The program requires physicians to meet standards relating to personal qualifications, the environment of care, clinical care processes, and results of patient care.

Licensure

Dr. Joelle Lescop (Medical College of Quebec) described licensing procedures in Canada. Licensing is carried out after an individual receives a university diploma and completes the specialty requirements. The practitioner submits not only to an exam to measure knowledge, but also to an evaluation of clinical competencies in real practice for five days. The system in Canada is unique in that the state is the payer and a database is maintained that permits the government to locate each professional. Thus, the government has the ability to track physicians and their performance. The state also regulates the educational process, determines income levels, and sets caps on the number of individuals who can enter a particular specialty per year.



Conclusions

Several important conclusions were drawn from the information presented and from the small group discussions. In general, it was felt that systems of health care service delivery vary throughout the world as well as political processes of health care reform and methods of quality assurance. Thus, it was concluded that the social, cultural, and political context of a particular country should be considered before designing a quality program, with emphasis placed on primary and intermediate care.

In addition, it was felt that proposals for quality improvement should be comprehensive, to include accreditation, licensure, and certification. Voluntary accreditation was considered the most reasonable approach such that client participation is stimulated and that standards are promoted and established. The accreditation process would be most effective if it were designed by and adapted to the needs and resources of individual countries. Accreditation would be a valuable quality assurance approach not only in hospitals, but also all health care institutions within the system of services.

Most countries have a standard system for licensing professional practitioners; however, this is a purely bureaucratic process that does not evaluate the quality, knowledge, or competence of the practitioner. Licensing should remain the responsibility of the state, which is legally authorized to do so and can maintain a database to support quality control. However, objective measurements have not been designed to evaluate the impact of the process. Also, there is a disparity in standards between countries in relation to the licensing of institutions (e.g., hospitals).

Certification procedures also vary between countries. A universal definition and process of certification would be helpful to all Latin American countries. Unfortunately, incentives for certification

are primarily economic. Specialists who are certified are more likely to receive referrals and consequently, higher wages. The focus of certification would be better placed in assuring quality of care, rather than creating competition between professionals.

Recommendations

After two days of sharing information, four small groups were assigned specific topics—accreditation, licensure, certification, and the role of the government. These groups developed the following recommendations, which were discussed during the final round table:

- Create a national plan for assuring the quality of health care services and make it a priority
- Develop a legal framework that supports the correct application of standards
- Include a mechanism to incorporate scientific and technologic advances (i.e., evidence-based medicine) into medical care
- Include the certification, licensure, and accreditation of health providers (individuals and institutions) in the process of quality improvement and in the national plan for health services
- Develop a culture of quality
- Reinforce professional ethics and include human rights
- Reinforce continuing professional education
- Develop a glossary of quality terms for the region
- Construct an integrated approach to quality measurement
- Take into account cultural and ethnic differences in the development of processes
- Establish incentives that promote and reinforce the processes
- Promote the participation of scientific societies, associations, educators, and health authorities
- Establish certification and evaluation of educational programs for health professionals





Development of a Hospital Accreditation Program: The Zambian Experience

Dr. Mwendaweli Maboshe and Mrs. Joyce Tembo, Central Board of Health of Zambia

Anne Rooney, RN, MS, MPH, Executive Director, Consulting Services for Joint Commission Resources, Inc.

ZAMBIA, a developing country of nine million people located in southern Africa, faces multiple and serious health challenges as a result of its significant resource limitations, widespread poverty, rising unemployment, waterborne diseases (e.g., cholera and dysentery), tuberculosis, and the HIV/AIDS pandemic that has devastated much of sub-Saharan Africa. In response to these formidable challenges, Zambia initiated a major health reform effort in the mid-1990s, resulting in a restructuring of health sector planning and financing, as well as monitoring and evaluation structures and functions. In support of this reform effort, and with the sponsorship and technical assistance of the Quality Assurance Project (QAP), Zambia instituted a national quality improvement and accreditation initiative in 1997.

Because of the lack of standards or regulations for the performance or evaluation of the majority of Zambia's approximately 80 hospitals, Zambian health leaders identified the development of a mechanism for establishing standards and evaluating hospitals as a reform priority. In order to facilitate standards development and the design of an accreditation program, a multidisciplinary advisory group entitled the Zambia Health Accreditation Council (ZHAC) was established as a first step.

The ZHAC was actively involved in developing and field-testing a first draft of standards that identified 13 key functional areas for every hospital (Figure 1), as well as 49 performance standards and associated measurable criteria. A sample performance standard and associated measurable criteria for the functional area Admission and Assessment are

shown in Figure 2. The set of draft standards was then distributed to all hospitals and health professional associations throughout Zambia as part of a consensus-building process known as a "field review." The reviewers' responses were overwhelmingly in favor of adopting the standards, with some modifications.

Following the field review, the standards were revised and a draft survey process developed and field-tested at hospitals of various sizes and types, ranging from a 100-bed mission hospital in a rural village to an 1,800-bed teaching hospital in the capital city of Lusaka. The survey methodology included a combination of leader, patient, and staff interviews; building and equipment tours; observation of patient care; document review; and clinical record review. All areas of the hospital, from patient care to the operating theater, laboratory, pharmacy, radiology, kitchen, laundry, and central sterile supply are included in the scope of the hospital accreditation survey process. Because of limited resources and the relative absence of formalized written policies and procedures in most Zambian hospitals, much of the survey's emphasis is on evaluating processes and outcomes of care through observation and interview.

The Monitoring and Evaluation Unit of the Central Board of Health, operating under the direction of the Ministry of Health, currently administers the hospital accreditation program. Accreditation surveyors were selected and trained. The group was comprised of physicians, clinical officers, nurses, dentists, pharmacists, and medical technologists. A team of three surveyors was assigned to conduct the



on-site hospital surveys. Each new surveyor completed a three-day didactic training course on the standards and survey process; followed by an on-site preceptorship at several hospitals, before being assigned to independently conduct a survey.

The standards and survey process are designed to assist hospital leaders and staff in prioritizing their resources, needed improvements, and funding. The major functional areas requiring improvement, as demonstrated in the initial surveys, were as follows:

- general hospital infrastructure supports, (e.g., building and equipment maintenance)
- availability of adequate supplies (e.g., soap, gloves, laboratory reagents, radiology film, medical equipment) and essential medications
- documentation of standardized processes or written policies and procedures in patient care, laboratory, radiology, and pharmaceutical services
- infection control practices, policies and procedures, and surveillance
- environment of care issues (e.g., fire safety and disaster preparedness)
- adequate and competent staffing for safe patient care

Despite the severe resource limitations of a developing country such as Zambia, both hospital leaders and key stakeholders within the country, including

the Minister of Health, believe that many improvements in health care delivery processes are achievable and that the standards will help to prioritize resource allocation and planning.

Throughout 1998 and the first half of 1999, consultative surveys were conducted in all hospitals in Zambia as part of a major field education and consultation effort. The final “rollout” of the accreditation program, whereby actual accreditation decisions and written findings will be distributed, is planned for the last half of 1999. As part of the operations research component of QAP, a multi-year impact study is being conducted in which performance of the standards will be measured for a set of randomly selected cohort hospitals over time, and improvements will be noted.

In addition to monitoring compliance with defined structures and processes identified in the accreditation standards, the cohort hospitals will be evaluated for improvements in patient and organizational outcomes that are expected to be related to

improved processes (e.g., a reduction in nosocomial infection rates or an increase in patient satisfaction). The study will be among the first of its kind to measure the impact of organizational standards and accreditation on improvements in health care delivery and hopefully will provide valuable information to guide the development of similar health reform and improvement initiatives in other developing countries.

Figure 1

Key Functional Areas of the Zambian Hospital Accreditation Standards

- Admission and assessment
- Laboratory services
- Radiology services
- Pharmaceutical services
- Patient care
- Patient rights
- Continuity of care
- Environment of care
- Infection control
- Leadership
- Quality assurance
- Human resource management
- Management of information



Figure 2

Functional Area: Admission and Assessment

There is an established process for admitting patients to the hospital that prioritizes care based on the assessed needs of the patient.

Intent Statement: The order in which patients are seen for admission is determined by their degree of need. Patients with immediate needs are given priority for assessment and intervention. The hospital designs and implements an effective and efficient process for admitting patients that considers the following elements:

Scoring				
	Met	Partially Met	Not Met	Not Applicable
a				a) Registration process is completed.
b				b) Patients with immediate needs are prioritized for assessment and intervention.
c				c) There is a standard for checking waiting times of patients in Outpatient Department and Admission.
d				d) Communication of information between departments and staff involved in care.
e				e) Timely completion of requested diagnostic testing.
f				f) All of these processes are documented in policies and procedures and standardized within the hospital.

Sources of Information:

1. Interviews with clinical and nonclinical staff addressing the registration process
2. Observation of the admitting area
3. Interviews with patients and families
4. Patient records

The Zambian approach to applying quality assurance to its hospital system is unique for a developing country facing such enormous health and social problems. If successful in standardizing hospital care processes and improving health out-

comes, the Zambian model of hospital accreditation could serve as a model for other countries around the world.





Self-Regulation of Hospitals: A Private Sector Initiative in Mumbai City, India

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THE issue of quality in health care services assumes special significance in countries with limited resources. In such instances, the private sector, which often provides questionable quality of care and more often than not functions without regulation and accountability to authority, dominates health care services. Many countries, operating under structural adjustment programs, have policies that support and promote increased involvement of the private health sector in the delivery of health care services. Thus, health ministries have endeavored to find ways and means to ensure that private health care services provide quality care (e.g., enacting legislation for hospitals,¹ evolving standards for hospitals, setting up accreditation systems, setting up accreditation systems, establishing QA programs,² and setting up health care facilities).

The scenario described above is similar to the situation in India. Recent studies show that 60 to 70 percent of ambulatory care patients and 40 to 50 percent of hospitalized patients solicit medical care from the private health sector, which accounts for 4 to 5 percent of the gross domestic product. But too often, services offered by private health care agencies are characterized by over-prescribing, unnecessary use of injections, over-investigation, and prohibitive cost. Because a majority of Indian states do not have laws or standards governing private hospitals, there is a virtual absence of

monitoring or accountability for most provider hospitals.

To address this concern, India is exploring various methods of providing and monitoring the quality of private health care services, including the viability of self-regulation for private hospitals through an accreditation system.

From August 1997 to June 1998, Mumbai City assessed and documented the needs and views of various stakeholders (various hospital owners and administrators, specialist and consumer associations, government functionaries, financial and insurance companies, and patients) about the possibility of creating an accreditation body for private hospitals. A number of tools, including a mailed questionnaire, a semi-structured interview schedule, a structured interview schedule, and two workshops generated quantitative and qualitative data.

The study called attention to areas of agreement and disagreement among the stakeholders but noted overall consensus regarding the need and desire for an accreditation body. Most stakeholders thought that hospital owners, consumers, and the government should play a leading role in establishing such a body. They further agreed that the body should assess and assist hospitals in maintaining and upgrading standards to ensure continuous quality improvement. A majority of those involved felt that

¹ Until recently, only the states of Maharashtra, Delhi, and West Bengal had an act for regulation of private hospitals. Due to pressure from consumer organizations, the states of Tamil Nadu, Bihar, Punjab, Manipur, and Kerala are in the process of enacting legislation.
² All India Institute of Medical Science, New Delhi is working on a QA program for hospitals. Additionally, there is a project undertaken in the four states of India, namely, Andhra Pradesh, West Bengal, Punjab, and Karnataka, to improve quality of care in secondary hospitals.



the accreditation body should monitor consumer satisfaction pertaining to physical aspects of health centers, medical equipment, qualification and number of staff, type of treatment, and follow-up care.

The stakeholders also believed that the forum should function as a non-profit body, that hospitals should be graded, and that internal assessments should be conducted by participating hospitals (followed by evaluations from external teams), and that the body should provide recognition and rewards to hospitals that satisfy standards. Stakeholders' views differed regarding the monitoring of the number of hospitals and beds in a geographical area, professional fees and hospital charges, incorporation of patient redress, and disclosure of assessment findings.

In response to these findings on stakeholder needs and heightened interest in creating an accrediting body, Mumbai City established the Forum for Healthcare Standards (FHS). The FHS consists of hospital owners' representatives, professional bodies, consumer and nongovernmental organizations, nurses' associations, and government representatives. FHS is currently at a formative level, though the potential exists for it to become a credible accreditation body on the basis of a collaborative and democratic system that addresses the needs of all stakeholders through open dialogue. Ideally, participants will mutually acknowledge areas that need strengthening while working cooperatively towards solutions.

For hospitals with 10–50 beds, FHS is involved in setting standards for structural design, equipment, and medicine, including wards, labor rooms, operating theaters, essential drugs, reception rooms,

consulting rooms, changing rooms, pantries, medical records, and waste management. The FHS is simultaneously considering system- and process-related issues, including grading, method and periodicity of assessment, and financing of the body, as well as other areas (e.g., indicators). Subsequently, the forum plans to develop performance standards and indicators for specialties and superspecialties.

Administering an accreditation system is not an alternative to the government's role in regulating health care, but is rather an additional, more collaborative role for governments, given the present scenario of changing health care systems. The present efforts (which are seen as formative) in Mumbai demonstrate how the introduction of accreditation systems in many developing countries can improve the quality of care through cooperative alliances and partnerships. Furthermore, they model a process for implementing accreditation system that is practical, indigenous, and relevant to the unique health care concerns of individual countries.³

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³ The author notes that findings continue to be disseminated to other parts of the country. Several states in India have shown an interest in the work done in Mumbai City.



This article is based on the author's direct experience with the development of the initiative in Mumbai City and on the following sources of information:

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What's New

Upcoming Conferences:

17th International Conference of the International Society for Quality in Health Care. September 13–16, 2000. Royal College of Surgeons, Dublin, Ireland. Fax: 353-1-402-2458 or Email ISQua at Conferences@rcsi.ie

American Society for Quality, 54th Annual Quality Congress and Exhibition. May 8–10, 2000. Indiana Convention Center and RCA Dome, Indianapolis, Indiana. <http://aqc.asq.org>

Products and Publications:

"Quality: A Focus on Results"—a profile of three companies that made a commitment to continuous quality improvement. Free from The American Society for Quality, 800-248-1946.

Health Care Quality Review – a compendium of articles, strategies, case studies, and proven quality tools for the implementation of effective quality programs. Call 800-655-5597 or Email: customer.service@aspenspubl.com. Order #10678 for \$79.00.

QCI International, publisher of *Quality Digest*, sends out monthly a free Email newsletter titled, "Timely Tips for Teams." If you are interested in receiving the newsletter, please write to don@qci-intl.com for more information.

Quotable Quotes:

"The real key to quality is the behavior of our people. To bring about the level of quality that is required to survive in the 21st century we need to change the way our people—all people, from the boardroom to the boiler room—think, act and behave."

H. James Harrington, *Quality Digest*, July 1999



Quality Improvement in South Africa: The COHSASA Accreditation Initiative

Stuart Whittaker, Managing Director, COHSASA

Anne Rooney, RN, MS, MPH, Executive Director, Consulting Services for Joint Commission Resources, Inc.

IN a variety of industries worldwide, accreditation is recognized as a symbol of quality indicating that an organization meets certain performance standards. In 1992, a set of multidisciplinary accreditation standards appropriate to health care delivery systems in South Africa was developed as a pilot project. Three years later, the Council for Health Service Accreditation of Southern Africa (COHSASA) was initiated to develop an accreditation program for South African health care facilities that includes hospitals, sub-acute care facilities, psychiatric programs, and primary health care clinics.¹

COHSASA's vision is the development of a cost-effective accreditation program for South African health care facilities that will enhance their performance, be seen by the public and funders as a hallmark of quality, and result in quality patient care. The specific objectives of COHSASA are highlighted in Figure 1.

COHSASA Standards

In South Africa, COHSASA has established close links with national and international professional organizations that actively participate in the standards development process. Several key concepts underpin all standards, individually and in the aggregate. These concepts are relevant to standards used to judge minimum expectations, as well as to those identifying exemplary practices. They include the following:

- The focus of standards is on the patient and, when appropriate, his or her family; on the provision of services to meet the identified needs of patients, consistent with the mission and resources of the health care organization; and on the protection of and respect for basic patient rights.
- Health care organizations have a basic obligation to understand the needs and expectations of those whom they serve and the extent to which they are meeting those needs and expectations.
- The leaders of a health care organization have a responsibility to provide effective management; services that are responsive to community needs for preventive, curative, and palliative services; and foster a culture that supports continuous improvement in the performance of the organization and the quality of the services provided.
- The standards address and provide a framework for a systematic approach to the measurement and improvement of care processes and outcomes of care, and the continual reduction or elimination of risks to patients.

Most frequently, structural standards define the expectations of entry-level organizations, while standards that identify expected outcomes are most useful in determining exemplary practices. Accreditation standards that reflect an appropriate mix of types are most likely to enjoy broad application and use.

¹ *In the South African health industry, to earn and maintain accreditation, an organization must undergo an on-site survey by a team of health professionals at least every two to three years.*



Figure 1

COHSASA Objectives

- *The development and implementation in South African health care facilities of standards that defined requirements for quality health service provision throughout all levels of service delivery*
- *Accurate assessment of existing performance of participating facilities through the identification of deficiencies and requirements for meeting the prescribed standards*
- *Empowerment of staff through the introduction of quality improvement and participative management processes*
- *Optimal use of resources to effect compliance with the standards according to the financial constraints confronting the country while considering the rights of all South African citizens to receive quality care as specified in South Africa's constitution*

The standards are comprehensive and establish performance and structural expectations that address the care of the patient, the creation of a safe environment of care, and the effective management of the organization. Such standards can be grouped into two general categories—those that focus directly on **the care of the patient**, and those that focus on **the management of the organization** (Figure 2).

The Accreditation Process

The accreditation process includes the preparation of facilities for accreditation, the external survey, and the decision process.

The Preparatory Stage

The baseline survey is carried out at the start of the program to determine the starting level of compliance with the standards. This is followed by introduction of a multidisciplinary continuous quality improvement approach and a second internal survey.

The COHSASA program has been designed to empower employees to achieve accreditation through their own efforts, based on a multidisciplinary continuous quality improvement (CQI) approach. CQI is a management method that seeks to develop the organization in a new way so that, in an orderly and planned fashion, everyone at all levels can play an active role in understanding the problems and the processes of the work.

A COHSASA facilitator is appointed to work with a participating hospital for a period of 9 to 18 months for first-time entrants, depending on how far the hospital is from meeting the standards and 3 to 6 months for second-time entrants, depending on the

Figure 2

COHSASA Standards Areas

Standards that focus on the care of the patient address at least:

- *Patient rights*
- *Access to care*
- *Continuum of care*
- *Patient assessment*
- *Care planning and the delivery of care*
- *Education of the patient and his or her family when appropriate*

Standards that focus on the management of the organization address at least:

- *Leadership of the organization*
- *Roles and responsibilities of staff*
- *Management of information*
- *Creation and maintenance of a safe environment for patients*
- *Infection prevention and control*
- *Quality management and human resource management*



need of the hospital. Facilitators are highly qualified, experienced, and well-trained health professionals who work with hospital staff to assist them in their efforts to meet the program's standards through personal involvement and networking.

Facilitators conduct in-service training programs aimed at helping hospital staff to understand the standards and to be in a position to assess the degree of compliance the hospital has achieved in meeting the standards. Hospital staff are then taught to use a variety of analytical tools to gain an understanding of the work processes. As a result, they develop a sense of ownership of the program and become empowered to use their own skills and resources to understand the standards, assess their hospital's level of compliance, and work towards meeting the standards. Staff members do this by applying a systematic problem-solving methodology based on sound project management principles.

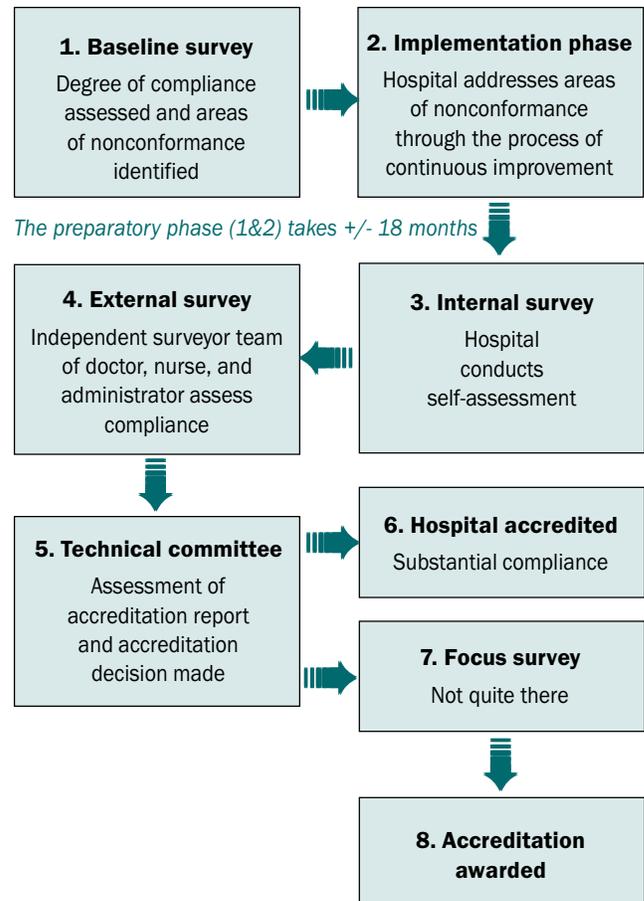
Toward the end of this phase, staff conduct a second internal survey to evaluate their own performance. The results are again processed by COHSASA, and the hospital receives extensive feedback regarding its compliance with the standards.

The External Survey

The external survey is conducted by COHSASA's external surveyor teams and is usually made up of a doctor, a nurse, and an administrator. The external survey is carried out after the preparatory phase and is designed to provide an independent assessment of the hospital.

The Accreditation Decision

Reports are submitted to a technical committee that consists of experts in the field of health care. The committee makes recommendations to the Board on the accreditation of participating hospitals. The



Board, based on the recommendations of the technical committee and the evaluation of all reports, awards the certificate of accreditation.

Accreditation Impact Research Study

In May 1999, under the sponsorship of the Quality Assurance Project (QAP), a two-year multinational research study assessing the impact of the COHSASA accreditation program on selected structural, process, and outcome measures was initiated. Using a randomized control methodology, the study monitors improvements in standards compliance over time in ten control hospitals, as well as in ten intervention hospitals that are participating in the COHSASA accreditation program.



Figure 3

Results achieved

Through June 1999, 101 public and private hospitals and 48 primary health care facilities and subacute care facilities have been accredited by COHSASA.

In both the private and the public sectors, a large proportion of facilities failed to meet the core standards at the baseline survey. Even at the time of the external survey, a large number of hospitals still had important deficiencies that had to be addressed by a focus survey. However, the attitude of participating hospitals was extremely positive, and the hospitals rapidly put the remaining requirements in place. Even in those public hospitals where resources are extremely scarce, magnificent achievements are being made. Extra effort, however, will be required to enable some rural hospitals to achieve compliance. Given this effort, compliance is not out of reach.

In addition, a joint U.S.–South Africa research team will measure the performance of the study hospitals on 10–15 quantitative and qualitative indicators, such as rates of post-operative wound infections, patient perceptions of care, general hospital sanitation, completeness of medical records, and neonatal mortality. This study, along with a complementary accreditation impact study in Zambia, is expected to be seminal research studies evaluating the impact of accreditation on health outcomes.



Field Activities Update

Use of Quality Design in Guatemala

In 1999, QAP began working with the Ministry of Health (MOH) of Guatemala to: 1) support the MOH in the decentralization of health care services; 2) introduce a focus on quality to all levels of care through the application of different QA methods and tools; and 3) design and implement information, education, and communication campaigns at the local level of health facilities regarding the new quality of services offered.

As part of its second objective, QAP has been introducing quality design tools and techniques to health personnel of six hospitals in the Western High-

lands. The hospitals are using quality design to redesign obstetric services. QAP experience has shown that the redesign or design of obstetric services based on client needs leads to higher client satisfaction.

In each hospital teams composed of all levels of hospital personnel were formed. The teams conducted focus groups to identify the needs and requirements of the women who came to the hospitals for obstetric care. The focus groups revealed several chief complaints: perceived misdiagnosis by providers, lack of privacy and comfort, poor explanation of the procedures and treatment by providers, long waiting times for care, difficulty understanding the language of hospital personnel, and having to share beds with other

patients. This dissatisfaction with hospital amenities and poor communication of providers resulted in women infrequently coming for care, and thus greatly increasing the rate of high-risk and problem pregnancies.

The quality teams used this information to make necessary changes in the waiting time and addressed features of the hospital that would make it safer and more comfortable. Now the teams are expanding their scope by training hospital doctors in clinical standards of care; introducing the provision of services at the level of the community center level, where most communities seek care; and incorporating regular monitoring and supervision in all activities.

Dr. Carlos Gonzalez L.



Focused Accreditation

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AS NOTED in the preceding articles, there is a growing expectation for improved quality in health services in both developing and developed countries. Traditional accreditation has proved to be a powerful quality improvement method, especially in hospital settings. More recently, a more selective or “focused” form of accreditation is being piloted, largely in primary health care settings in a number of countries. For the purpose of exploring this emerging adaptation of traditional accreditation, this article will introduce the term “focused accreditation,” though some may prefer the terminology “nonformal, informal accreditation” or “quality evaluation.” No doubt, as more experience is gained, the differences between focused and traditional accreditation will be clarified, as well as whether or not those differences merit the use of a new terminology “focused accreditation.” Hopefully this article will stimulate thinking about new applications of accreditation.

What is “Focused Accreditation”?

The term “focused accreditation” refers to the process by which a recognized body performs a selective (or focused) review of one or more functions of a health care organization (in contrast to all functions of the entire organization), and assesses its ability to meet a set of standards and criteria specifically related to the selected function or service area. Health care organizations which consistently meet the standards receive recognition from the assessing body, and may be awarded a symbol (e.g., star) to exemplify their achievement. The symbolic quality award and ensuing public recognition make focused accreditation a powerful vehicle

to improve individual provider and organizational performance. The process also fosters increased public expectations of quality service.

Focused accreditation is a relatively new term, and hence, may evolve with time to reflect new applications of the accreditation process in diverse care settings. The examples discussed below are drawn from project experiences. Currently there are few large scale focused accreditation programs (UNICEF’s Baby Friendly Hospitals being the exception).

How Does Focused Accreditation Differ from Traditional Accreditation?

Development of Standards, Health Facility Setting, and Accrediting Body

Accreditation is a formal process whereby a recognized body (often a nongovernmental organization) assesses a health care organization’s abilities to meet pre-determined, published performance standards.¹ The standards it uses to assess performance are commonly developed by expert committees working with the accrediting body and are revised periodically to reflect advances in technology, treatment regimes, or policy changes. Traditional accreditation has commonly been applied in hospital settings, although recently its application in primary care and community settings has been receiving considerable attention. It uses a formally recognized body to analyze performance results and determine accreditation status. The accrediting body may be a government body or a parastatal, but is most often a nongovernmental, private (often nonprofit) organization.

¹ Licensure, Accreditation, and Certification: Approaches to Health Services Quality, A. Rooney et al, 1999, p. 3.



Figure 1

Comparison of Traditional and Focused Accreditation*

Traditional Accreditation	Focused Accreditation
<i>Development of Standards</i>	
Uses pre-determined, published standards or guidelines	May use pre-determined, published standards or guidelines, but may also stimulate the development of new standards specifically for the review
Standards tend to be process oriented, less emphasis on performance outcome measures	Standards include both process and performance outcome measures, with more emphasis on individual provider performance
Standards are optimal achievable, designed to encourage continuous improvement at organizational level	Standards are optimal achievable, designed to encourage continuous improvement at individual and organizational levels, with emphasis on self-assessment prior to external review
Standards focus on quality from organizational perspective, relative to client criteria of quality	Standards include more client perspective of quality
Standards are usually developed by an expert body and recognized nationally	Standards are more likely to be developed locally, with community and client input
<i>Health Facility Setting</i>	
Concentration on hospital accreditation	Concentration more on primary care facilities
<i>Accrediting Body</i>	
Accrediting organization is usually a legally recognized, established, and sustainable organization (often nongovernmental) with broad purview	Accrediting body may be constituted just for the purpose of a particular review, does not necessarily have a legal identity, and may focus on smaller region or specific geographic area
Accrediting body is often nongovernmental, independent from Ministry of Health	Accrediting body commonly is associated with (or part of) the Ministry of Health
<i>Scope of Assessment</i>	
Standards are focused on broad organizational processes or functions within entire organization	Standards are focused on specific processes inclusive of the entire organization
<i>Role of Self-Appraisal and QI Skills Development</i>	
Self-appraisal and QI skills development are not emphasized	Emphasis on self-appraisal and QI skills development, viewed as integral aspects of the process
<i>External Surveyors</i>	
Accreditation decision made by team of external peer reviewers, usually professionals	Accreditation team more likely to include community/clients as well as local providers and professionals
<i>Dissemination and Use of Results</i>	
Results available to public, but degree of public dissemination varies; traditionally used more internally by organization (this is changing with link to financial/government financial incentives)	Results purposefully shared with public/consumers to foster improved provider performance and stimulate demand for quality services
Voluntary process, but increasingly linked to financial “incentives”	Voluntary process, but commonly linked to public recognition and increasing public expectations for quality
<i>Tenure of Accreditation</i>	
Time between reviews varies, based on results of review, but typically is between 2 and 3 years	Time between reviews varies, but generally about one year

***Bold** indicates area of critical difference



Focused accreditation is more commonly used in primary health care facilities and is usually carried out by a newly constituted local organization or body established specifically to perform the focused assessment. The performance standards used in focused accreditation may be pre-existing, but are relatively unknown and are often newly developed for the purpose of focused accreditation. Hence, although pre-agreed upon by the participating organizations and the accrediting body, they may only be published with the start of the focused accreditation program. The accrediting local body for focused accreditation is more likely to be part of or directly associated with the Ministry of Health.

Finally, it is important to note that both focused and traditional accreditation are standards-based forms of evaluation, and use optimal, but achievable standards.

Scope of Assessment, Role of Self-Assessment, and External Surveyors

Traditional accreditation emphasizes organizational capability and performance, rather than individual practitioner performance. Hospital accreditation standards are usually arranged around key patient and organizational functions or departmental services. All functions or departments within the health organization are included in the scope of traditional accreditation; hence, it is the entire facility that is assessed. Specially trained surveyors perform the assessment, reporting their results to the accrediting body. Community representation is limited.

More recently, traditional accreditation programs (especially in developing countries) have included some element of self-appraisal and incorporated quality improvement approaches to assist the institution in its preparation for the external survey. Although the accreditation process itself encourages continuous improvement, traditional programs have tended to concentrate more on the external survey,

giving less attention to capacity building in the area of quality improvement (QI) methodological skills.

Focused accreditation also assesses organizational capability, but pays relatively more attention to individual practitioner performance. The standards it uses are more likely to be developed by local professionals, and may include community or client input. As the name implies, the scope of focused accreditation is more limited, concentrating on a particular type of service or organizational function (i.e., reproductive health or adolescent services), rather than the full range of functions performed by the health care facility.

While both traditional and focused accreditation use external peer reviewers to perform the assessment, reviewers for traditional accreditation tend to be professional providers or managers, while the review team for focused accreditation may include community members or clients. In addition, focused accreditation uses self-appraisal as a vehicle to incorporate quality improvement (particularly team-based problem solving) as an important component of the accreditation process, and puts more emphasis on the development of QI skills within the participating institution.

Dissemination and Use of Results, Tenure of Accreditation

Both traditional and focused accreditation are voluntary processes, with the results of their performance reviews available to the public. Although the dissemination of specific findings from traditional accreditation may be limited to the participating facility, the results increasingly have financial ramifications (i.e., approval to receive third party or public sector payments). Focused accreditation, on the other hand, is more commonly associated with a communication campaign to disseminate findings, in order to bring public “recognition” to the



providers and their facility, and to increase public awareness of quality. For this reason, the accrediting body of focused accreditation may reward facilities that achieve accreditation status with some symbol of quality (e.g., gold star). Although, monetary recompense may follow due to increased public utilization of an accredited facility, focused accreditation is less associated with funding agency decisions about reimbursement for services and more with increasing the public's knowledge and use of quality services.

The usual cycle of traditional accreditation is 1 to 3 years, with shorter intervals for those institutions given conditional accreditation, requiring specific improvements noted in the accreditation report. Focused accreditation relies on more frequent monitoring and may be repeated every 6 months to a year.

Because the concept of focused accreditation is relatively new, there are only a few experiences upon which its "characteristics" can be based. As the process gains wider use, the differences and similarities with traditional accreditation can be delineated in more detail, as well as the functional interface between both approaches when they co-exist within a country.

Examples of Focused Accreditation Programs

Gold Star (Egypt)

In Egypt, the Ministry of Health and Population (MOHP) teamed with the Ministry of Information (MOI) to launch the Gold Star Quality Program.¹ Research and evaluation of client perceptions of quality, as well as images of providers and services

associated with quality, were used to select a symbol of quality—the "gold star." A communication campaign was then undertaken to foster consumer recognition of the gold star as a symbol of quality family planning services, and to inform the public about realistic expectations of quality family planning services. Communication messages promoting provider and service quality were widely disseminated and influenced not only consumer, but also provider perceptions of quality.

During the campaign period, the MOHP concentrated on improving basic equipment and renovation of primary clinics, along with training physician and nurse providers. National Clinical Standards of Practice were implemented with 101 indicators of quality service. In addition, management and monitoring systems were introduced at family planning units, in conjunction with a computerized MIS that enabled providers to track quarterly indicator scores at each service delivery site. It was decided that a gold star award would be granted to any family planning unit that met all 101 indicators for two quarters in a row and retained by any facility that was able to maintain its score. Quarterly monitoring of the quality indicators in accordance with the National Clinical Standards promoted facility-based quality improvement.

A second phase of the communication campaign was launched after a sizeable number of units had achieved "gold stars"; it focused on promoting the specific local "gold star" clinic sites and the providers in them. Public recognition of gold star accreditation stimulated increased expectations and demand for such services, as well as increased utilization of gold star facilities.

¹ *The Gold Star Program was developed and implemented with technical assistance from JHU/CCP. References for this section include: Population Reports, "Improving Care and Raising Expectations" (H. Gebaly et al. ICPD 1998) and Communication Impact, "Egypt's Gold Star Quality Program Wins Clients and Communities" (CCP 1998).*



Proquali (Brazil)²

In the northeastern region of Brazil, several concurrent, but individually focused initiatives to expand coverage and improve the quality of reproductive health services met with limited success. The state health officials, USAID, and the three Cooperating Agencies (Management Sciences for Health [MSH], Johns Hopkins University/Center for Communication Programs [JHU/CCP], and Johns Hopkins Program in International Education and Training in Reproductive Health [JHPIEGO]) then developed an integrated, synergistic, client-centered performance improvement model. Essential to this model was the prior development and approval of reproductive health service guidelines (RHSG), which could serve as performance improvement standards for quality reproductive health (RH) service within the two participating states. During this period, decentralization also gained momentum, and local municipalities began to assume responsibility for health services, actively identifying service delivery gaps and strategies to improve the quality of local services.

The “Proquali” model includes: infrastructural supports, a clinic-based recognition process, and a performance improvement process. The recognition process coupled with the performance improvement process became an example of focused accreditation. One important element of the Proquali model of focused accreditation is its emphasis on self-evaluation. Self-assessment checklists for providers and managers of service delivery points are used as learning and performance monitoring guides. The checklists can be used to assess whether practices are consistent with the RHSGs and to identify areas needing improvement. External assessment is also conducted by members of the state Quality of Care

Recognition Commission (QCRC), established specifically to undertake the review and grant approval (focused accreditation in reproductive health) of participating primary health clinics.

In order to receive a QCRC assessment, a health clinic must successfully pass a two-day qualifying visit and then demonstrate that it has maintained the standards of quality RH for three months. During the pilot phase, 61 “recognition” assessment criteria were developed in five service areas: RH service delivery; infection prevention and control; Information, Education, and Communication Programs (IEC); physical plant and materials; and management infrastructure support systems. Each of the criteria was given the same value, one point. But, in order to satisfy each criteria, all items listed for verification had to be met. Furthermore, at sites with more than one provider, up to three providers had to be observed and all of them had to meet the items in order to receive the one point for that criteria.

During the pilot project, a clinic had to achieve at least 80 percent in each of the five service assessment areas in order to qualify for the second visit. Ninety-five percent of the total criteria had to be achieved at the second visit in order to be “recognized” by the QCRC. After the pilot, only one external assessment visit was built into the model, and the “cut-off” point for recognition was set at achieving 95 percent of the criteria. In this example of focused accreditation, results from the assessments serve the basis for both the quality improvement and the recognition processes.

² The Proquali model was developed and implemented with technical assistance from MSH, JHPIEGO, and JHU/CCP. Dr. Edgar Nechochea, JHPIEGO, kindly supplied the information for this section.



Baby Friendly and Mother Friendly Hospitals, Worldwide³

The Baby Friendly Initiative, co-sponsored by UNICEF and WHO, is one of the earliest and largest focused (or nonformal) accreditation programs. The initiative recognizes hospitals and birthing centers that create optimal environments for breastfeeding through the implementation of ten steps designed to promote successful breastfeeding. Hospitals or birthing centers make the decision to participate in the initiative through submitting an application, which includes a letter of intent, fee, and self-appraisal in regard to the promotion of breastfeeding. The “standards” for recognition consist of the “10 steps to successful breastfeeding.” When a participating hospital has implemented all steps, an onsite assessment is conducted by a WHO/UNICEF-appointed, “baby friendly” survey team, along with a review by the Baby Friendly External Review Board. Those hospitals assessed by the surveyor team and the Review Board to have successfully implemented all steps are deemed “baby friendly” and may display the logo.

The Coalition for Improving Maternity Services (CIMS) has a similar approach, delineating “10 steps of mother friendly care.” One of those steps is to incorporate the “10 steps of the Baby Friendly Hospital Initiative.”

Future Directions

As decentralization and health sector reform gain impetus in many countries, the responsibility and decision making for health care shifts to local authorities who may be expected to directly experience the benefits of quality service at their local facilities. Expectation and demand for quality services can then be translated into local authority

decisions regarding resource allocation and community pressure to maintain standards. One of the most important characteristics of focused accreditation programs is the emphasis on broad public recognition of quality, conferred by the award of a widely recognized symbol of quality. The symbol conveys status to the institution and its providers, often elevating their own expectations of quality performance.

A number of trends today foster the utility of focused accreditation programs: increased privatization of health services, the shift in public sector responsibility from service provision to policy and oversight for quality/standards, as well as health sector reform, which places the technical oversight of all medical services (private and public) under the aegis of the MOH and strongly encourages cost recovery. When clients pay for service, they demand quality and seek information indicating which service delivery sites or providers are rated as “the best.” Focused accreditation provides clients with an objective comparison (based on standards) between health facilities and may become a means for client participation in recognizing quality through consumer representation on the accrediting body.

It is likely that focused accreditation, with its more selective appraisal and emphasis on performance outcome measures at primary health centers, will also be useful for assessing home-based and community-based medical services—two rapidly expanding service areas. Finally, focused accreditation is particularly suited for promoting quality services for special populations with specific needs (e.g., adolescents or the elderly). The process can also help identify those “accredited” facilities capable of providing quality services and tailored for the needs of these special populations.

³ This section is based on information found in the QAP publication, “Licensure, Accreditation, and Certification: Approaches to Health Services Quality,” A. Rooney et al. 1999. p. 22-23.



ISQua Establishes New Accreditation Federation

Sean Yu, BA, Communication Assistant

THE International Society for Quality in Health Care (ISQua) is currently establishing the foundation for the first worldwide membership body to unite national health care accrediting organizations. The new body, federated in structure, will be known as the ISQua Accreditation Federation. Operating under the umbrella of ISQua, this special interest group will oversee the development of ISQua's Agenda for Leadership in Programs for Health Care Accreditation (ALPHA), the collective name for all of ISQua's accreditation-related activities.

ALPHA had its inception in a series of annual meetings, beginning in 1994, between representatives of long-standing national accreditation programs and those from countries where accreditation had recently been implemented or was being considered. In 1996, it was proposed that ISQua take the lead in developing and maintaining international standards and exploring ways in which accreditation organizations could work together as an international council. The launch of the ALPHA program by ISQua represents a major step forward in the development of a global approach towards aligning health care standards and accreditation processes.

The federation's final structure, council, and subcommittees were endorsed and fully operational for ISQua's Sixth Accreditation Symposium in October 1999. Reporting to the ISQua Executive Board, the Federation Council will manage the ALPHA program, which will have several components:

- Support for the development of accreditation activities in different countries

International Society for Quality in Health Care

Incorporated in Australia and consisting of members from more than 60 countries, the International Society for Quality in Health Care (ISQua) is a nonprofit organization that enables individuals and organizations with a common interest in quality health care to share expertise and experience via an international multidisciplinary forum. ISQua is already well known for its work in accreditation and standards. However, as Lee Tregloan, CEO of ISQua, comments:

"ISQua as an organization is about much more than accreditation and standards. An ISQua Board subcommittee steered the groundwork for ALPHA and, like many organizations, is now handing this to a more widely representative group. ALPHA will happen in parallel with other activities. Accreditation and standards development are seen as part of a range of methodologies required to facilitate quality in health care. Hence, ISQua is also developing interests in measurement and performance improvement, with the perspective that these aspects don't only relate to accreditation; other areas are working with governments on quality policy developments and also education programs."

ISQua's Sixth Accreditation Symposium was held on October 10–11, 1999, in Melbourne, Australia, just prior to the start of the 16th International Conference on Quality in Health Care, held October 12–15, 1999, also in Melbourne. QAP staff made two presentations at the October conference: "Improving Quality in a System of Care" and "Evaluation of QA Programs."



- Maintenance and further development of an international framework of principles to serve as the foundation for national health care standards
- Assessment and endorsement of national accreditation standards
- Maintenance and further development of an international set of standards for the operations of national accreditation bodies
- Peer-assessment services for national bodies
- Development of an “accreditation of accreditors” program

The Quality Assurance Project (QAP) has applied for Associate Membership in the ISQua Accredita-

tion Federation. Associate Membership indicates that an organization is in the process of developing an accreditation program, which, when fully estab-

lished, may qualify that organization to be a Full Member—an organization that performs accreditation of health care services as its primary function, addressing specific clinical areas or services. Benefits of membership include access to ISQua’s set of international standards as the basis of peer assessment and the

broadening of a member organization’s own scope of accreditation ability.



From the president of ISQua. . .

ISQua is now proceeding with implementation plans to assess national health care accreditation standards in line with the approved framework and several accreditation organizations have now expressed interest in being peer-assessed in the coming year for international “accreditation as an accrediting organization.” Full membership of the federation is available to ISQua member organizations that are fully operating as accreditation organizations. Associate membership is available to individual or organizational members of ISQua. Contact ISQua for details at www.isqua.org.au

New QAP Products

Bouchet, Bruno. 2000. Monitoring the quality of primary health care. *Health Manager’s Guide* 1(1) (Spanish and French).

Budeyeva, M. 2000. The Tuberculosis Case Management CD-ROM. *Quality Performance Learning Series* 1(2).

Kelley, E., C. Geslin, S. Djibrina, and M. Boucar. 2000. Improving performance with clinical standards: The impact of QA methods on compliance with the Integrated Management of

Childhood Illness algorithm in Niger, West Africa. *Operations Research Results* 1(2).

Knebel, E., S. Lundahl, A. Edward Raj, and H. Abdallah. 2000. The use of manual job aids by health care providers: What do we know? *Operations Research Issues Paper* 1(1).

Knebel, E. 2000. The use and effect of computer-based training in health care. *Operations Research Issue Paper* 1(2).



Improving the Implementation of IMCI

Edward Kelley, PhD, Senior QA Advisor

THE Operations Research (OR) Program of the Quality Assurance Project (QAP) has a mandate to develop and test cost-effective methods for quality assurance in developing countries. To inform partners in developing countries and collaborating agencies about results from the field, QAP is releasing regular OR updates in the *QA Brief*. This update features results of QAP's work in improving the Integrated Management of Child Illness (IMCI) algorithm, a set of clinical guidelines for the care of sick children under five years of age.

The IMCI algorithm is designed to treat the most common causes of morbidity and mortality in children worldwide: measles, malaria, pneumonia, diarrhea, ear problems, malnutrition, anemia, and lack of adequate immunization. WHO and UNICEF have introduced the algorithm in more than 50 countries worldwide.

Whereas considerable evidence exists that the correct application of IMCI will lead to effective treatment of sick children, in practice health workers often fail to comply with the complete algorithm. Health workers report that the algorithm is very time consuming, that they receive little ongoing guidance in correct use of the algorithm after training, and that drugs and supplies necessary for compliance are frequently unavailable.

QAP's OR Program has developed a multipronged strategy designed to address the many issues that hamper the implementation of IMCI in those countries where QAP is working. The priority areas of this strategy appear below.

Research is ongoing in virtually all of the above areas, with results from a number of studies now available. QAP, for example, has tried to improve health worker mastery of the IMCI algorithm by developing a computer-based training (CBT)

program, which has already been tested in Uganda. Here, the program earned wide praise from Ministry of Health officials and participants in an IMCI training course; they see the computer-based program as a useful and innovative tool for learning.

More important, results from the both posttest knowledge scores and scores on performance

in the field indicate no significant differences in performance between the computer-based training and the traditional IMCI courses.

However, the computerized course, through savings in facilitator time and in-class time, costs from 20 to 25 percent less than the traditional course. This study is ongoing with further results due in Winter 2000. Work is also underway to issue a Spanish translation of the program. This program is being developed with USAID in Bolivia.

Priority Areas for Effective IMCI Implementation

- **Mastery.** Health workers achieve sufficient knowledge and skill to perform IMCI correctly and efficiently
- **Attitudes.** Health workers have favorable attitudes towards IMCI
- **Consequences.** For health workers, the positive consequences of performing IMCI outweigh the negative consequences
- **Support.** IMCI-trained health workers have an effective support system
- **Resources.** Facility has adequate resources for correct performance of IMCI



Meanwhile, in Niger, the final results of two studies on IMCI are now available. One measured the cost impact of improved health worker compliance on provider time and drugs. The other examined the effect of two specific quality assurance methods—the structured feedback and quality improvement teams—in improving compliance.

The first study found that at reasonable levels of compliance (75 percent), IMCI has the potential to offer significant cost savings through more rational and efficient drug use without increasing the time providers must spend with clients.

The second study found that using structured feedback, an extremely affordable tool that comes to less than 25 percent of the cost of traditional training, has good prospects for improving health worker performance in problem areas of compliance. Quality improvement teams, in their own right, also

exhibited major potential as a tool for districts implementing IMCI. Facilities with active quality improvement efforts performed significantly better on IMCI indicators than comparable facilities without teams. These results are summarized below.

QAP plans to continue its work as a leader in studying and improving approaches to IMCI implementation through its OR Program. Reports from a number of studies will be available soon. In addition, the Uganda version of the IMCI CBT program is completed and a Spanish version is expected to be completed in Bolivia by Spring 2000.

For further information on any of these products, please contact Dr. Ed Kelley, Quality Assurance Project, at ekelley@urc-chs.com.



Results from the Field: Selected Findings of QAP IMCI Operations Research

Computer-based vs. traditional training

- No significant differences in knowledge or performance
- CBT course is about 20-25 percent cheaper than standard course, if costs of software and computers are not included

IMCI compliance results in drug savings

- Savings as high as 60 percent appear at highest levels of compliance (>85 percent compliance)
- In addition, time costs of client-provider encounters do not appear to increase at higher levels of compliance

Feedback raises low areas of IMCI performance

- Feedback is four times cheaper than traditional training
- Feedback improves certain assessment areas by 34–85 percent
- However, feedback does not seem to reinforce high-performance areas

Team-based QI can help workers improve performance

- Facilities with Quality Improvement teams are significantly (chi-square 7.001, p=0.008) more likely to perform above average on both overall IMCI compliance and specific IMCI indicators



Electronic Resources

QCI International

www.qci-intl.com

This full-service consulting, training, and publishing firm offers a source for products and services that fall under the total quality management umbrella. It focuses on teams, such as employee involvement teams, with special emphasis on building facilitator and team-leader skills.

Medical Quality Assurance (MQA)

www.doh.state.fl.us/mqa/

MQA is responsible for the planning, development, and coordination of programs and services of 18 regulatory boards, six councils, and five professions directly administered by the Florida Department of Health. MQA develops policies to effectively regulate medical professionals while protecting the health and safety of Florida residents. Many links available, including health care provider license look-up and information on regulated professions.

HQHq

www.hqh.org

This FUN site produces educationally certified learning material for today's worldwide population of health care professionals. The cost-effective, on-line training is designed to hold the interest of any user. The "Candhu" and "Nocandhu" soap operas and learning texts are based on real-life situations...with a twist. An "Evidence of Learning" section gives participants a chance to check their own progress (including their responses to text questions) via an Email review. A PGEA/CPD certificate, giving two hours' credit for each unit completed, is available.

International Journal of Health Care Quality Assurance

www.mcb.co.uk/cgi-bin/mcb_serve/

This professional journal, published in Great Britain, provides a forum for the international exchange of the theoretical and practical aspects of quality assurance and management in health care. It also endeavors to develop knowledge about quality assurance and its implementation in health care organizations. Articles submitted to the journal should be original contributions not under concurrent consideration for any other publication.

IQMA Classifieds

www.openhouse.org.uk

Email address: iqma@openhouse.org.uk

This site represents a clearinghouse for those interested in all aspects of quality assurance. Individuals may post classified ads in these categories: quality training courses, recruitment, articles for sale, articles wanted, research, publishing, and general classifieds. Not specifically oriented to health care.

AddVal Inc.

www.addvalinc.com

AddVal Inc., founded by nurse executives, specializes in credentials and primary verification, quality improvement, and accreditation consultation. Its mission is to add value to health care; it creates products and services for physicians, managed care companies, and hospitals. Its nurse consultants create specific work plans for organizational needs and resolve issues while adhering to customer timelines.

American Society for Quality (ASQ)

www.asq.org

ASQ promotes the development of individual and organizational performance excellence, providing information for the newcomer as well as the skilled professional. Its Standards and Certification link provides information on the ISO 9000 and ISO 14000 standards, QS-9000 requirements, and ASQ certification program. An on-line catalog is available. Also helpful is the Virtual Quality Network link, a directory of products and services for quality and continuous improvement.

Registrar Accreditation Board (RAB)

www.rabnet.com

The RAB site offers access to searchable databases to find an auditor, training course, or accredited registrar. It is a complete source for information on RAB-approved ISO 9000 and ISO 14001 registrars, training course providers, and individual auditors. It also provides quarterly updates on its national certification and accreditation programs. The user can download an application package for QMS auditor or QMS internal auditor certification.

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