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Publication Date
1972

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A SECOND LOOK AT ACCREDITATION OF REHABILITATION FACILITIES: SOME QUESTIONS AND CAUTIONS

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January, 1972

Working Paper No. 175/RS005

Project for Cost Benefit Analysis and Evaluation of Rehabilitation Services

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The research reported here is being supported by a grant from the Rehabilitation Services Administration of the Social and Rehabilitation Service, U.S. Department of Health, Education and Welfare.

Recently, Mr. Warren Thompson, formerly the director of the California State rehabilitation agency and now with the Federal Regional office in Denver, published an article in Rehabilitation Literature in which he sought to convince fellow colleagues of the desirability of formal accreditation of rehabilitation facilities.[1] In other fields, accreditation has sought to establish the legitimacy of institutions or facilities through essentially a licensing procedure. Such an approach has been taken toward schools and hospitals, for example, to both correct abuses and protect the public from malpractice or deception.

In addition to these basic functions, some (like Mr. Thompson) perceive that an adequate accreditation process would win many gains in improving the over-all performance of facilities. Mentioned frequently are:

- standardization of rehabilitation service expectations for public administrators, clients, rehab professionals, and the general public by a clear statement of desirable criteria;
- assurances to the public of proper expenditures of state and federal funds for rehabilitation services;
- improved professional image of rehabilitation facilities;
- means of self-improvement of individual facilities through the process of evaluation for accreditation.

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[1] Warren Thompson, "Accreditation: Key to Survival and Financing of Government Rehabilitation Programs in the 70's," Rehabilitation Literature, Vol. 32, No. 10, October, 1971.

The list could be longer, but the consensus seems to be that accreditation is a good thing. The bothersome point is that the presently available accreditation system is only a first step toward an adequate procedure. Mr. Thompson would imply that all we must do is turn the "key" in the door and stride through into an ever brighter tomorrow. It may not be so easy. We should look more closely at the "key" we now have in hand.

The Present Accreditation System

Those qualities that might apply to an ideal accreditation scheme appear to be nascent in the existing procedures, but hardly fully developed. All the proper subject areas for standards appear in the most prominent efforts. The major divisions covered in the 1970 manual of the Commission on Accreditation of Rehabilitation Facilities (CARF), for example, are: Purposes (of the facility), Organization and Administration, Services, Personnel, Records and Reports, Fiscal Management, Physical Facilities, and Community Involvement and Relations.[2] Similar items appear in the newly revised "Standards for Accreditation" of the Goodwill Industries of America[3], and in the "Standards for Rehabilitation Facilities" developed by the federally appointed National Policy and Performance Council of HEW/SRS.[4]

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[2]Commission on Accreditation of Rehabilitation Facilities, _Standards Manual for Rehabilitation Facilities_, September, 1970.

[3]Goodwill Industries of America, Inc., _Standards for Accreditation_, Washington, D. C., 1971.

[4]U. S. Department of Health, Education, and Welfare, Social and Rehabilitation Services, _Standards for Rehabilitation Facilities_, Washington, D. C., 1969.

All three efforts represent significant progress toward meaningful accreditation. Yet all are also similar in what may be a serious misdirection -- they may be accrediting the wrong areas.

In all three cases (CARF, NPPC, and Goodwill Industries), we find a thoroughness verging on pre-occupation with structure, and a corresponding lack of depth with function. Structural questions explored fully include: corporate organization; legal requirements; staffing procedures and other personnel matters; financial, safety, and insurance concerns; administrative record-keeping, production and sales criteria (for workshops). Recognizing the considerable importance of each of these topics in guaranteeing a viable business position for the facility, we must note with dismay the dearth of materials concerning the pursuit of the ostensible central rehabilitative function of the facility.

For example, the recommended staff/client ratios for various functions appear to be all but arbitrary. There is no obvious relationship between the ratio and quality of service the staff member is supposed to provide. We are given few (or no) hints from what hat the magic numbers have been plucked.

Most of the other standards involving client services are merely listings: does the facility have some sort of program it can call "work evaluation"? "work adjustment"? "Psychological counseling"? The content of the programs is not delineated with the care used elsewhere in the standards to specify tediously what items should appear on the client's work record. The form of the service delivery (i.e., structure, inputs) is closely examined, while the performance (functions, outputs) is given only cursory notice. If we truly want to improve the performance

of rehabilitation facilities, the emphasis should be reversed. Are the services provided effective in meeting the clients' needs? Do clients obtain and hold competitive employment after leaving the facility? Is clients' earning power enhanced? Can we distinguish levels of quality of service provided? These obvious performance standards are not addressed.

Even with this emphasis on form, there is at least one element of structure that is ignored in the current standards: optimum size of the facility. Unfortunately, it may be the most critical. One recent study of 73 sheltered workshops in five states, one of the few studies actually based on data analysis using information voluntarily reported by facilities, has concluded that a minimum of 150 clients in average daily attendance are needed before a workshop can reach the threshold level economic efficiency which allows it to survive.[5] The author of that study freely admits that his findings are based only on rough data with unknown biases for generalization to the entire national population of facilities. But surely the conclusion is suggestive. No amount of accreditation and improved management may be able to save a workshop that is simply too small. Only increasing public subsidies will allow such workshops to survive. Moreover, many observers believe that diversity of contracts and job training programs improves the rehabilitation value of a client's workshop experience. Yet diversity often appears to be possible only with increased size.[6] It is thus

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[5]Vladimir Stoikov, "Economies of Scale in Sheltered Workshops," in William Button (ed.), Rehabilitation, Sheltered Workshops and the Disadvantaged, Region II Rehabilitation Research Institute, Cornell University, Ithaca, 1970.

[6]Michael M. Dolnick, "Contract Procurement Practices of Sheltered Workshops," National Society for Crippled Children and Adults, Chicago, 1963. Ronald W. Conley, Economics of Mental Retardation, Baltimore: Johns Hopkins Press, forthcoming - 1972.

highly dismaying that consideration of size is missing from the current proposed standards on which accreditation is to be based.

Why is the Present System Being Supported?

With present standards concentrating on inputs alone, and perhaps then not even on the most relevant inputs, we might wonder why such criteria might be praised as the "key to survival"? Thompson himself implies the answer.

Thompson rightly notes that cost-benefit analysis (what he calls "the current budgeting preoccupation"):

> ...can lead program administrators philosophically to investing money where the greatest, least expensive, and quickest results accrue. This, as opposed to where the need is greatest, presents the budgeting problem.
> (p. 300)

To avoid such criteria that might show needed rehabilitation programs in a bad economic light, Thompson suggests that: "Accreditation is without question one of the most effective tools a public administrator can command." (p. 300) Thompson goes on to list the ways accreditation can help agencies, but we must take exception to most of them.

True, an agency self-study can be most helpful in pin-pointing problem areas -- if the standards are directing the agency's attention to the proper areas. True, the report of a review team may aid in obtaining federal grants -- if available grant programs are relevant or funded adequately to allow for meaningful improvement. True, the accreditation process can serve as a management study of the agency -- but does that assume the agency's main problem area is management? Finally, Thompson concludes that an accredited agency justifies its continued support by right of its accreditation. We can only accept

this if we first agree that the accreditation has accurately evaluated the operations of the facility relevant to the rehabilitation needs it was created to serve.

All this suggests why accreditation is now being stressed. First, some suspect that performance measurement and the stern economic criteria of cost-benefit and cost-effectiveness analysis may treat programs like sheltered workshops harshly. (We should remind ourselves, however, that such an economic evaluation of the workshop approach has never been conducted. Our fears may be groundless.) Second, even if this suspicion did not exist, few in the rehabilitation field have a thorough understanding of the alien economic concepts hidden within such analytical techniques. The techniques naturally arouse anxiety, and in any event we do not know how to apply them. We similarly are not confident that we know how to evaluate or even measure performance of facilities -- a problem facilities share with the rest of the rehabilitation movement, and indeed with social service programs generally. Third, accreditation standards have evolved over the years as "nuts and bolts" guidelines developed by managers and practitioners <u>within</u> rehabilitation. We feel safe to assume therefore that the standards will not be particularly threatening to current operating patterns.

The strategy then is to place into the hands of federal program administrators a money-allocation tool friendly to the form of existing facilities. The tool offered is accreditation by professional rehabilitation organizations. Though the administrator should be expected to prefer to look at program <u>outputs</u>, this tool, as we have seen, focuses instead on <u>inputs</u>. A clear and reasonable rationalization exists for this peculiar reversal which makes the reversal

acceptable to administrators. The expertise and time required to conduct a thorough cost-benefit analysis of rehabilitation programs and facilities simply exceed present capacities. The administrator must thus accept accreditation as "second best."

Problems with the Dynamics of the Accreditation Process

Even if we had a fully acceptable set of accreditation standards (and we have strongly suggested here that we do not), there are many other questions concerning the accreditation process that have not been met.

One important area of concern should be the costs, both in time and money, for the conduct of an accreditation survey of a facility. Existing accreditation surveys now cost anywhere from $200 to $1000. Who should bear this cost? It is conceivable that the accreditation fee could not be met by many small facilities operating on ever tighter budgets.

Another question is the time required to cover all facilities. To be effective, accreditation must apply to all available facilities, i.e., there can be no "grandfather clause" exempting any facilities from investigation. Not until all the facilities have been rated can the state agencies or individuals choose their source of rehabilitation services with any degree of certainty. The magnitude of this task cannot be understated: in California alone, there are over 300 rehabilitation facilities and workshops.[7]

A further question related to time is that of how much time to grant a facility to correct flaws discovered in the accreditation survey.

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[7]California Human Relations Agency, Department of Rehabilitation, California State Plan for Workshops and Rehabilitation Facilities, 1971, Sacramento, 1971.

At one extreme, we could foresee the necessity of granting exemptions or "provisional accreditation" which cannot be followed up, with the result that most of the goals of accreditation are not met. At the other extreme is the prospect of such vigorous enforcement of accreditation standards that some facilities are forced to close by what would effectively be a boycott.

Perhaps the most important question to address is the one most feared: what do we do if many of the facilities are found to be substandard? If we close them down, what do we do with all their clients? We can foresee several possibilities:

- The clients can be added to the welfare rolls. The effect of this is unclear. If rehab clients are publicly subsidized anyway, it shouldn't make much difference which public agency handles the funds. The question revolves more around the idea of "work" itself as the most worthy pursuit of man. With much discussion now about a four day work week, this philosophy may soon be questioned.
  It may even be less expensive (from the public point of view) to provide maintenance income to the disabled through welfare, rather than spend public money in support of substandard rehabilitation facilities that are of no demonstrable worth to the clients, other than "giving them something to do."
  Most important, the addition of new numbers of the disabled to the welfare rolls could provide added impetus toward reform of both welfare and rehabilitation.

- Increased funds can be made available to bring facilities up to standard. This is a more positive and reasonable action

than throwing the clients onto welfare. Nonetheless, it would require clear guidelines to establish whether a substandard facility was making "progress" -- such guidelines do not yet exist.

- _Consolidation and strengthening of facilities_. The successful (accredited) facilities could act as models for others, and could become the hubs of a more centralized rehabilitation service delivery system. Consideration of economies of scale of large operations must be carefully balanced with maintaining the responsive, local character of rehabilitation facilities, of course. It is a clear possibility, however, that the successful facility could be "rewarded" by increased grants for expansion. In this way, clients turned out of substandard facilities could come to receive better service from these expanded facilities.

- _Preferential public policies toward facilities_. While this would have the equivalent effect of out-right grants, it would have greater long-term importance. If, for instance, there were long-term, guaranteed public contracts with workshops, or centralized contract procurement for groups of smaller workshops, the gains of a steady work-flow could be reflected in better job training and better rehabilitation.

The possibilities listed above are merely the first that come to mind. We believe that not enough thought has gone into projecting the likely outcome of a formal accreditation system. The effects suggested above point to the fact that we should devote much more effort to this kind of thinking before instituting such a system.

Cautions in the Pursuit of Accreditation

We do not quarrel with the intent or spirit of any existing accreditation instruments or organizations. All are making important contributions to the advancement of rehabilitation. We only ask that certain caveats be acknowledged in the further advocacy of such standards:

1. We readily admit that the current emphasis on management concerns (inputs) is not born of a disregard for human services. Rather, the emphasis simply reflects the fact that we have no truly adequate performance standards for rehabilitation services. Totaling up arbitrary "points" for quality of client services along with, say, the completeness of employment records -- an approach taken by some accreditation instruments -- is perilously close to adding apples and oranges. We should not pretend that we have expertise for such operations and thereby mislead clients, administrators, and the public alike. We should confess our limitations.
2. We should give careful thought to whether we really wish to make the present accreditation standards mandatory. Do the standards ask what we truly want to know? If outputs are our real concern, we should amend the standards accordingly. Whom do the standards serve? We might want a tool for use by an administrator, a planner, a policy maker, a manager, or perhaps by clients. Can one procedure serve all well?
3. If widespread use is made of on-site survey teams, what kind of people do we want on those teams, and what subjective

biases will result? What weight should be given to their personal views?

4. Last, in due consideration of the magnitude of effect that mandatory, standardized accreditation might have, we must exercise extreme caution in promoting as <u>final</u> standards which are in fact <u>experimental</u>. The experiment may be entirely justified at this time when the financial crisis in government threatens the continuation and expansion of rehabilitation services. Mr. Thompson clearly and strongly makes this point.

It is not at all clear, we believe, that bad standards are better than none. It is even less clear that inadequate standards will long remain credible if rigidified into a bureaucratic structure. Such structures can become unlikely or unwilling to yield to the pushes and pulls of a dynamic field like rehabilitation.

For an eloquent critique of the concept of accreditation, we might consider the path higher education has taken in the recent past. There, accreditation for a student meant the attainment of a degree in a particular field, with assumptions of competence in a specified body of knowledge. As times changed, the needs of society made many traditional areas of study obsolete. The result was a considerable turnabout in the content and structure of curricula at many major institutions. Yet the old structure still remained for conferring degrees with the same obsolete titles and the same ostensible "rights and privileges thereto pertaining." Educators, students, and even employers now often complain that the educational process has become a ritual to be endured so that the graduate might obtain his "entrance

papers" into "accepted" society. For some, the degree has fallen from an affirmation of quality to just another rubber stamp.

Those intent on initiating accreditation into rehabilitation should profit from such experiences, and hopefully avoid the "accredibility gap." Accreditation is potentially too valuable to the rehabilitation facility, and to the field as a whole, to be relegated to a required check-mark on a grant application form.