to opioid use disorder’s assorted health consequences—things like HIV seroconversion—and there’s really no evidence that medical marijuana would do the same,” Selzer added.

Both the FDA and the Substance Abuse and Mental Health Services Administration have tried to dispel the long-held notion that medication treatment essentially substitutes 1 drug for another, even if someone takes the medication for a lifetime. The National Institute on Drug Abuse also explains that the approved medications don’t produce an almost immediate high followed by a quick comedown, and they reduce cravings for and the euphoric effects of opioids.

But the medications are vastly underused. The FDA has advocated for wider availability by suggesting broader insurance coverage and offering the treatment in criminal justice systems. A study published earlier this year showed that among nearly 18,000 Massachusetts adults without cancer who survived an opioid overdose between 2012 and 2014, only about one-third received medication treatment within a year afterward. The data also showed that methadone or buprenorphine use was associated with lower rates of all-cause or opioid-related mortality.

“[T]he area to really focus on the most is getting effective treatment to people who need it,” Cunningham said.

Note: Source references are available through embedded hyperlinks in the article text online.

The JAMA Forum

Accreditation, Quality, and Making Hospital Care Better

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Ensuring quality is a critical component of high-performing health systems. Having access to health care is not enough; patients who enter the health care system—whether a clinic, a hospital, or another venue—need to be confident that they will receive care that is safe, effective, and consistent with the latest clinical evidence. This is particularly important for hospitals, where patients are acutely and often severely ill, but all the data suggest that the quality of care is far from optimal. There are large variations in complications and mortality rates across hospitals.

The concerns about level and variations in hospital quality are not new. We have known for decades that hospitals differ in their ability to provide high-quality care for patients—and our national strategy for ensuring and improving care has been accreditation. The notion is simple: using an external, independent body that applies objective criteria to ensure that hospitals are implementing evidence-based practices to maximize patient outcomes. Although the logic may be sound, it has not been clear whether this approach works.

Despite a national strategy in which our government, through the Centers for Medicare & Medicaid Services (CMS) essentially pushes most hospitals to get accredited, patient outcomes often lag. A 2017 news story in the Wall Street Journal reported that hospitals accredited with gold stars are struggling to ensure even basics around safety and quality. The newspaper reported that 350 hospitals cited in inspection reports in 2014 as being in violation of Medicare requirements had accreditation from The Joint Commission at the time, and that more than a third with accreditation had additional violations later in 2014, 2015, and 2016. There appears to be a disconnect between what accreditation is meant to do vs what it might be doing.

Does Accreditation Work?

Does accreditation ensure high quality care? Policy makers certainly think so. CMS requires that hospitals either be accredited or pass state inspection to receive Medicare reimbursement. If pursuing accreditation, hospitals may choose to work with one of several accrediting bodies, to whom they pay a fee to undergo the survey process. Although this option may be appealing to hospitals that want to avoid the high costs and administrative burdens associated with accreditation, the vast majority of acute care hospitals opt to become accredited.

The major accreditor in the United States is The Joint Commission, which is used by 4,477 hospitals, or about 88% of accredited US hospitals. It is one of the more expensive accrediting organizations, with annual fees that can run into the tens of thousands of dollars, with additional costs of surveys. Yet the direct fees are only a small portion of the investment required; staff time, consultation services, and other aspects of preparing for the surveys can rack up large indirect costs. One case study found that direct survey fees were only 7% of the total costs associated with the accreditation of a hospital. And preparing for an accreditation survey feels like a chore, requiring focus on minute administrative details where the link to patient outcomes is not immediately clear.

Examining the Link: Accreditation and Quality

Given the high costs and extra workload associated with accreditation, systematic evaluations of the value of accreditation would be extremely helpful. And there is some evidence available. Much of the data suggest that hospitals that are accredited are more likely to adhere to evidence-based process measures, although the difference is
often limited. For example, one study of 205 accredited and 525 nonaccredited rural critical access hospitals that reported data to the CMS Hospital Compare database found that patients with heart failure treated at accredited hospitals were more likely than those at nonaccredited hospitals to receive an angiotensin-converting enzyme inhibitor, and patients with acute myocardial infarction were more likely to receive aspirin upon arrival to accredited hospitals. Another study of 3891 hospitals also found that nonaccredited hospitals had worse performance on a series of process-of-care measures and were less likely to improve their performance over time.

In addition to looking at process measures, one study of 4221 hospitals, using data from the mid-1990s, found that outcomes for patients with acute myocardial infarction were better in hospitals accredited by The Joint Commission than in nonaccredited hospitals. The differences were small, and there was substantial variation among accredited hospitals. The authors questioned whether accreditation itself improves quality of care, or if better-performing hospitals are simply more likely to choose to become accredited.

These data are helpful but we have lacked contemporary data on the utility of accreditation. Given that so much has changed in hospital quality over the past 2 decades, it is unclear whether the findings from the 1990s still apply today.

Therefore, my colleagues and I recently investigated whether patient outcomes were better at accredited hospitals and whether those differences were particularly pronounced at The Joint Commission-accredited hospitals. The study of 4400 US hospitals, of which 3337 were accredited (2847 by The Joint Commission) and 1063 underwent state-based review between 2014 and 2017, used Medicare data to compare mortality, readmissions, and patient experience across hospital accreditation status. First, we examined patient outcomes in accredited hospitals compared with nonaccredited hospitals, finding no statistically significant difference in 30-day mortality for medical or surgical conditions. Accredited hospitals performed slightly better on readmissions measures for medical conditions but not for surgical conditions.

Next, we examined whether patient outcomes at The Joint Commission-accredited hospitals differ from those at hospitals accredited by other entities. On average, we found no difference in mortality or readmission rates based on accrediting organization.

Finally, we examined patient experience across accrediting bodies and hospitals undergoing state survey. Surprisingly, accredited hospitals scored significantly lower on patient experience ratings, performing particularly badly on communication, staff responsiveness, and hospital quietness and cleanliness. The findings are clear: accredited hospitals do not seem to be providing better care.

The Future of Accreditation
Based on the limited amount of data and more recent evidence, should we give up on accreditation? Absolutely not. Hospital accreditation remains a cornerstone for ensuring at least a basic level of quality, at least for things that the health care system assesses. Patients want to know that a hospital provides safe and effective care, and accreditation, if done right, can be a powerful tool to offer that assurance. The problem, it seems, is that accrediting organizations are not focusing on what actually matters to patients. The criticism that these organizations spend enormous amounts of energy requiring hospitals to focus on things like signs in the hallway or how documentation is done appears to have some merit. We need to reexamine the standards required for accreditation to ensure that they are promoting what’s actually important: the health, safety, and optimal experience of patients.

These are not uniquely US concerns. Over the past few decades, accreditation has been gaining traction around the world. As global health care leaders increasingly focus on improving quality of health systems, accreditation has been considered a valuable tool. This is particularly important as countries rush toward universal health coverage, so ensuring that the delivery system is of adequate quality becomes paramount. The emerging data should add some caution to the excitement that accreditation alone will offer that assurance of high-quality care.

So what approach can policy makers take to ensure that accreditation achieves the goals we want? First, there must be a clear delineation of high-quality care (good outcomes, good experience) and that must be the guiding principle behind accreditation. Hospitals should be held accountable for those outcomes. Accrediting bodies should focus on those processes and structural factors that have been convincingly shown to be associated with good outcomes.

The current approach leaves too much room for focusing on things that aren’t important, often leading to a lot of work but not better care. If we change the way we approach accreditation, we can ensure that we are actually providing quality care for all.

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