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Site-level evidence-based practice accreditation: A qualitative exploration using institutional theory

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Abstract

Accreditation is gaining ground in human services as leaders find ways to demonstrate the quality and legitimacy of services. This study examined site-level accreditation for SafeCare®, an evidence-based practice designed to prevent and reduce child maltreatment. We leveraged two waves of qualitative data to explore the perspectives of trainers, organizational and system leaders, and program developers who participated in an initial rollout of a site-level accreditation process for SafeCare. Institutional theory was used to frame accreditation's potential benefits, burden, and impact. Findings highlight specific considerations for the human service environment, including the inherent resource scarcity, interdependence among organizations, and the impact of cost and slow-moving bureaucratic processes.

Keywords

EBP implementation; accreditation; institutional theory

Introduction

Accreditation is considered an important and accepted part of quality assurance and improvement activities and is a common practice in healthcare and public health (Brownson et al., 2012; Greenfield & Braithwaite, 2008). It has also been a topic of interest in the human service organization (HSO) literature for decades (Lee et al., 2007; Lynch-Cerullo & Cooney, 2011; Lee et al., 2011; Lee, 2014a). Leaders of HSOs may choose to get accredited for various reasons. First, accreditation functions as "a potential signal of quality, credibility, and trustworthiness" (Lee, 2014a). Second, policymakers may mandate or offer incentives (e.g., higher reimbursement rates) for accreditation. By linking it to purchaser-provider

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contracts, accreditation can potentially expand funding opportunities for organizations (Lee et al., 2007; Lee, 2014b). HSO leaders may also use it as a form of voluntary organizational development, to assert their position in the local marketplace, or for marketing purposes (Lee, 2014b). Potential downsides of accreditation include decreased morale if employees perceive the process as imposing more "rules and regulations," increased costs, and increased demands placed on time and internal resources (Lee, 2014a; McMillen et al., 2008).

The Council on Accreditation (COA) currently works with over 1600 HSOs (Home-Council on Accreditation, n.d.). Other accrediting bodies that HSO leaders may engage with are the Commission on Accreditation of Rehabilitation Facilities (CARF) and the Joint Commission on Accreditation of Healthcare Organizations (Home- CARF International, n.d.; The Joint Commission- Accreditation & Certification, n.d.). There are also several types of accreditation that HSO leaders may consider. One is general accreditation given to the organization. COA, for example, offers organizational-level accreditation that can be maintained over four years. Accreditation-granting organizations may also provide more specific program-level certification. For example, CARF has an option for residential substance use disorder treatment programs to receive a Level of Care certification (Level of Care Certification by CARF, n.d.). This certification demonstrates an organization's use of evidence-based policies and procedures and adherence to the American Society of Addiction Medicine's standards.

Of most relevance to the present study is a third type: site-level accreditation specific to a particular evidence-based practice (EBP) or model. This type of accreditation is bound to the delivery of a particular EBP and is conferred by the EBP developer rather than an outside body like the COA or CARF. A 'site' may be one or more organizations, and accreditation status is conferred at the site-level. This is different than accreditation at the individual provider level. HSO leaders in child welfare may be familiar with individual-level EBP certification for providers and/or trainers for interventions such as Triple P, The Incredible Years, or Multidimensional Treatment Foster Care (Chamberlain, 2003; Sanders et al., 2002; Webster-Stratton & McCoy, 2015).

Using conceptual frameworks in implementation science to understand accreditation

Existing implementation frameworks offer the conceptual foundations for understanding the impact of accreditation. For example, the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework is a process and determinant framework that describes key factors and mechanisms that may be important across the implementation phases (Aarons et al., 2011; Moullin et al., 2019; Nilsen, 2015). Two EPIS framework constructs spanning outer (broader system environment) and inner organizational contexts are "bridging factors" and "innovation factors." These constructs are particularly relevant to understanding the potential impact of accreditation on HSOs (Aarons et al., 2011; Moullin et al., 2019).

Bridging factors are the bi-directional and dynamic connections between the outer and inner contexts, and can be operationalized as relational ties, formal arrangements, or processes (Lengnick-Hall et al., 2020, 2021; Moullin et al., 2019). Previous work described how site-level accreditation can be a process type of bridging factor that connects

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program developers with organizations implementing the EBP (Lengnick-Hall et al., 2021). Treating the accreditation process as a bridging factor directs our attention to the specific ways that EBP implementation and sustainment may be affected by the bridging factor (accreditation), including resources that are exchanged. Resources that may be exchanged between EBP developers (e.g., the National SafeCare Training and Research Center, NSTRC) and organizations (e.g., HSOs implementing SafeCare) could be EBP information, implementation data, social norms and network benefits (Lengnick-Hall et al., 2021). The EPIS framework includes innovation factors, which describe intervention characteristics (e.g., features of SafeCare) and the activities, actions, and engagement of EBP developers with organizations. The innovation factors construct explicitly accounts for potential adaptations that may result as part of implementation processes over time (Moullin et al., 2019).

Site-level EBP-specific accreditation can also be thought of as an implementation driver. In the Active Implementation Frameworks, drivers are methods for diverse activities including developing innovation-specific competencies, making organizational changes, and engaging leadership to use innovations with high fidelity (Fixsen et al., 2021). Accreditation also touches upon several constructs in the Consolidated Framework for Implementation Research, including external policies and incentives in the outer setting domain, organizational incentives/rewards and access to knowledge and information about the EBP in the inner setting domain, and reflecting upon and evaluating implementation progress and quality in the process domain (Damschroder et al., 2009). Finally, modifying accreditation standards to require or encourage EBP use is an implementation strategy in the Expert Recommendations for Implementing Change (ERIC) compilation (Powell et al., 2015). What is missing in these implementation frameworks and constructs is theoretical guidance that helps HSO leaders understand and plan for site-level EBP specific accreditation, and optimize potential benefits while minimizing burdens, given the unique features of the human service context.

Using institutional theory to understand accreditation in human services

Human service organizations exist within highly institutionalized environments, and they must demonstrate legitimacy to secure limited resources and survive (Bunger et al., 2017; Lynch-Cerullo & Cooney, 2011; Schmid, 2004; Spitzmueller, 2018). Institutional theory helps explain why certain structures exist and how organizations mirror (or are isomorphic to) the “institutional myths” in and “ceremonial” expectations of the surrounding environment (Meyer & Rowan, 1977). One of the originally stated consequences of this isomorphism is that organizations “become sensitive to, and employ, external criteria of worth” and assessment (Meyer & Rowan, 1977).

In this paper, we build upon existing HSO literature that has considered institutional isomorphism within the context of accreditation (McMillen, 2007; Wells et al., 2005, 2007, 2014). For example, accreditation from an EBP developer may be viewed as a form of external validation and assessment. Conforming to an institutionalized structure, like accreditation, can demonstrate outward legitimacy and an organization’s “fitness” to deliver a particular EBP (Meyer & Rowan, 1977). However, accreditation status may be

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disconnected from, or not fully reflect, how the EBP is implemented in the organization's everyday operations. This "decoupling" between external standards and what happens inside the organization reflects institutional theory's "ceremonial" aspect (Meyer & Rowan, 1977).

DiMaggio & Powell (1983) defined the construct of an organizational field as "those organizations that, in the aggregate, constitute a recognized area of institutional life: key suppliers, resource and produce consumer, regulatory agencies, and other organizations that produce similar services and products" (p.143). The concept of the organizational field shifts the unit of analysis from an individual organization or population of organizations to a bounded system of "interdependent organizations operating with common rules, norms and meaning systems" (Scott & Davis, 2007; pg. 118). An organizational field relevant to understanding site-level, EBP-specific accreditation may include organizations that (a) direct the accreditation process, e.g., EBP program developers, (b) deliver the EBP, and (c) fund the delivery of the EBP.

Accreditation may reflect the three types of institutional pressure: mimetic, normative, and coercive. Mimetic processes describe how organizations "model themselves after similar organizations in their field that they perceive to be more legitimate or successful" (DiMaggio & Powell, 1983). Thus, EBP program developers and implementing and funding organizations may seek legitimacy by mimicking what other professional bodies do. Accreditation may also elicit an organizational response to normative pressure (Bunger et al., 2017). DiMaggio and Powell (1983) originally conceptualized normative pressure as deriving from a field's increased professionalization. This pressure is exerted by more ingrained and elaborate social networks, standards around who can join the field (e.g., skill requirements or common promotion practices), and various socialization processes that communicate and reinforce shared vocabularies, norms, and expectations (DiMaggio & Powell, 1983). Accreditation could increase professionalization around the implementation of an EBP. Finally, HSO leaders may choose to have their agency accredited in an EBP because of coercive pressures within the organizational field. This field can be shaped by the policymakers who mandate an EBP's use, the expectations of funders with whom HSOs depend for resources, and the program developers who may act as gatekeepers to offering a particular intervention.

Research questions

This paper examines site-level accreditation for SafeCare®, an EBP proven to prevent and reduce child maltreatment and parent recidivism in child welfare (Chaffin et al., 2012; Hecht et al., 2008; Silovsky et al., 2011). Several research questions guide this exploratory qualitative study. First, how do organizational and system leaders learn about SafeCare accreditation, make sense of its imperatives, and decide to become accredited in light of the existing HSO environment? Second, how do HSO leaders, system leaders, intervention developers, and SafeCare trainers operationalize the accreditation process? Third, how do different stakeholders perceive the value and burden of accreditation, including its impact on internal operations? The overarching goal of this paper is to illustrate how institutional theory can enhance our understanding of and use of site-level, EBP-specific accreditation in HSOs.

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Materials and Methods

The EBP

SafeCare is a home-visitation EBP aimed at reducing child maltreatment with a focus on reducing child neglect. SafeCare has been scientifically studied for over 30 years using research designs including statewide effectiveness trials (Chaffin et al., 2012), large service system scale-up (Chaffin et al., 2016), smaller clinical trials (Silovsky et al., 2011; Whitaker et al., 2020), and single subject designs (Gershater-Molko et al., 2003). SafeCare providers work with families in the home through communication, problem-solving, and modules focusing on child health, home safety, and parent-child/infant interaction (National SafeCare Training and Research Center, 2016). The child health module supports caregivers in addressing risk factors associated with medical neglect. The home safety module supports caregivers in anticipating and addressing risk factors associated with environmental neglect and unintentional injury. Finally, the parent-child/infant interaction module supports parents in developing positive child or infant interaction to promote bonding and positive attachment (National SafeCare Training and Research Center, n.d.-b).

Through ongoing in-vivo fidelity assessment and supportive fidelity coaching sessions, SafeCare coaches work with providers to ensure intervention model adherence (National SafeCare Training and Research Center, 2017a). In the SafeCare curricula, trainers are described as experts in the SafeCare model and its implementation (National SafeCare Training and Research Center, 2017b). Trainers teach and support coaches and are responsible for supporting high-quality implementation processes at their designated site(s) (National SafeCare Training and Research Center, 2017b). Providers, coaches, and trainers achieve and maintain certification (National SafeCare Training and Research Center, 2016) from the NSTRC. For our analysis, "site" typically refers to a single organization but in some situations, multiple entities have applied for accreditation together in a single service system.

Study context

This study is embedded within a large, long-term, mixed-methods research initiative to examine the implementation and sustainment of SafeCare in nine child welfare and/or mental health systems in two U.S. states (Aarons et al., 2014). More broadly, SafeCare has been implemented in 26 states in the United States and currently has approximately 100 accredited sites. Previous work describes how and why organizations decided to provide and sustain SafeCare, and the system drivers (state/county level regulations, funding decisions, and contracting conditions) that have shaped SafeCare implementation over time (Willging et al. 2015; Green et al. 2016; Willging et al. 2016; Trott-Jaramillo et al. 2018; Willging et al. 2018; Lengnick-Hall et a. 2020a; Lengnick-Hall et al. 2020b).

The two states in this long-term research initiative include the longest-implementing SafeCare sites (8+ years), with some even preceding establishment of the NSTRC (National SafeCare Training and Research Center, n.d.-a). At the time of data collection for the present study, six of the nine systems were classified as "fully" and one as "partially" sustaining SafeCare; the remaining two systems were no longer delivering SafeCare and thus are not

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included in this analysis (Aarons et al., 2016). In fully sustaining systems, core elements of SafeCare were maintained at a sufficient level of fidelity after initial implementation support had been withdrawn, and adequate capacity existed to maintain these core elements (Wiltsey Stirman et al., 2012). Partial sustainment described the system that met only some core elements (e.g., did not conduct model-required fidelity monitoring) after the withdrawal of initial implementation support. For this manuscript, these are the "seven service systems" from which data for these analyses were derived.

To offer insight into how HSO and system leaders prepared to manage the accreditation process, we collected data related to initial reactions after learning about this effort (Wave 1 data). Next, we collected data on how NSTRC staff and SafeCare trainers understood and described accreditation requirements (Wave 2 data). We integrated Wave 1 and Wave 2 data to describe the perceived value and burden of accreditation across the different stakeholders.

Participants and data collection

The qualitative interviews described in this study were conducted by anthropologists with advanced degrees, including Author 2. The Wave 1 interviews occurred in-person at the participating sites; the Wave 2 interviews occurred over the phone. On average, the interviews were one hour in length, digitally recorded, and transcribed. For both waves, the samples largely consisted of White, non-Hispanic women who were trained in the field of social work. Participants received a $30 gift card as remuneration for completing the interview.

For the Wave 1 data collection in 2016, we contacted HSO and system leaders by email to invite them to participate in an interview on SafeCare sustainment. In this study, system leaders included state- or county-level directors or administrators of agencies that serve children and families involved in the child welfare system. HSO leaders represented upper leadership roles at the HSOs that contracted with the system to provide SafeCare. The final sample included 25 HSO leaders and 17 system leaders, representing 18 HSOs embedded in the seven service systems. We conducted 18 individual interviews and ten small group interviews (2 to 4 people). The semi-structured interview guide prompted discussion of implementation commitment, current SafeCare status, funding arrangements and contracts, features of the system-HSO relationship affecting SafeCare sustainment, and adaptations made during SafeCare implementation. Interviews coincided with the dissemination of information regarding the new NSTRC accreditation process at the sites, prompting us to inquire into what participants had heard about the efforts to accredit agencies that provide SafeCare and to ask about their initial impressions of the process.

For the Wave 2 data collection, we contacted NSTRC staff and trainers by email to invite them to participate in an interview about the accreditation process. The final sample consisted of two NSTRC staff members and ten trainers (representing ten of the 18 organizations in the 2016 wave) from the seven service systems, totaling 12 individual interviews. Many of the trainers worked with coaches and providers employed by the organizations that provided SafeCare in their respective service systems.

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Separate but complementary semi-structured interview guides were created for the NSTRC staff and trainers. The guides focused on interactions between NSTRC staff and the trainers, accreditation experiences, and opinions about the benefits, drawbacks, and perceived impacts associated with accreditation. The NSTRC staff guide specifically asked about challenges that affect agencies' ability to meet SafeCare implementation standards and how NSTRC helped agencies overcome them, how accreditation was conceptualized and rolled out, and what NSTRC hoped to accomplish by having agencies obtain accreditation. The trainer guide asked about the responses to accreditation roll out, how communication with NSTRC changed over time, and the extent to which the trainer made use of the tools offered by the NSTRC to facilitate delivery of SafeCare. Complete interview guides are included as appendices.

Analysis

Authors 1 and 2 used an iterative analytic process. Author 1 reviewed all transcripts and developed an initial codebook using institutional theory-based sensitizing concepts. The sensitizing concepts allowed us to determine how concepts from institutional theory were "manifest and give[n] meaning" in this particular study context (Patton, 2015). Several codes were descriptive codes (e.g., value of accreditation [network relationships] – to agency; value of accreditation [legitimacy] – to agency) that characterized the topic of a given passage in our dataset (Miles et al., 2020). Others were concept codes (e.g., ceremonial nature of accreditation) that "symbolically represented a suggested meaning broader than a single item or action" (Miles et al., 2020, p. 66). Author 2 reviewed and provided feedback on the codebook and text segments corresponding to the proposed codes. Author 1 assessed all transcripts again, inputting the coded material into a matrix whereby the transcript ID comprised rows and the final codes comprised columns (Miles et al., 2020). Matrix cells included summarized passages and direct quotes. The matrix allowed for comparing the frequency and importance of codes, including differences in stakeholder perspectives. To enhance rigor, Author 2 reviewed and approved the completed matrix. Rigor was further enhanced when during each analytic step, Author 1 created memos that documented coding decisions, Author 2's feedback, and reflections about the matrix patterns (Miles et al., 2020; Padgett, 2017). This manuscript fully adheres to the Standards for Reporting Qualitative Research (O'Brien et al., 2014).

Results

HSO and system leader reactions to learning about SafeCare accreditation

This section addresses our first research question related to how HSO leaders learned about SafeCare accreditation and made sense of its imperatives and the decision to become accredited. At the time of 2016 data collection, seven (of 25) organizational leaders and four (of 17) system leaders had not yet heard about SafeCare accreditation. Initial reactions among HSO leaders were mixed. Some HSO leaders expressed confusion over the specifics of the accreditation process (e.g., questioning why each organization needed to be accredited rather than the system as a whole). As one HSO leader remarked, "I don't want to say trepidation but there's just a little bit of curiosity about what that's going to look like. Certainly, anything that has additional cost associated with it brings up concerns." Worry

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about how to pay for accreditation costs, including having enough advanced warning, emerged prominently in six of the 18 HSO leader interviews.

Prior experience with accreditation produced different reactions to the impending SafeCare accreditation process. For some, it was a facilitator to quality service delivery. One leader explained,

> "We're going through our accreditation right now for [program name] and so I actually see the value in accreditation. I know it feels like, 'Oh, do we really need to do this?' But I actually think it's a really good thing. I can understand why NSTRC is doing it."

For other HSO leaders, prior accreditation experience made them wary. A second leader shared,

> "One of our other programs funded through [funder name] is going through an accreditation process…. I know that was a very intensive process that that program went through, and they had to put like a dissertation together of all the policies and procedures…. It makes me nervous if that's what it [the accreditation process for SafeCare] would be."

System leaders were more removed from the early communications about the accreditation process and relied on the SafeCare trainers (housed within the provider organizations) to share information disseminated by NSTRC. However, some system leaders expressed concerns about the logistics that they would need to navigate, such as securing funding, slow-moving bureaucratic processes, and the risk of compromising the system's SafeCare program due to noncompliance with accreditation standards. A system leader pondered the implication of accreditation for the multiple HSOs funded in the system to provide SafeCare: "We're going to have to build that into the contract. That's not built into our funding right now." This system leader added,

> "Then also too, how often is it [accreditation requirements] going to change?... I know they're really recommending it but if we do not because say we can't afford the fees then what happens? Do we get discredited? And is there another training that's required with it? If the [system] were to fund it, it would take months to arrange something like this. The [system] process is a little cumbersome to pay for this kind of thing with approvals. If our providers funded it, it could go much faster, but they would probably have to eat the cost."

Participants underscored that the ability to respond quickly to program changes can directly affect implementing organizations. For example, another system leader noted how in the past, the government entity funding SafeCare had no additional financing to cover unanticipated changes related to SafeCare delivery, which meant that HSO leaders had to find a way to pay for it "out of the kindness of their hearts." An HSO leader echoed the implications of accreditation for reimbursement rates set at the system level:

> "I'm sure there will be discussions within the [system] or just internally about, 'Okay this changes our rate if we have to do this, to maintain this particular

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> evidence-based practice, then we have to adjust our rate accordingly so that we cover those costs.'"

These findings reflect important features of the organizational field within which accreditation is being implemented. They highlight the interdependence among the organizational actors charged with meeting accreditation standards (HSOs) and those responsible for initial and long-term funding for accreditation compliance (service system actors). These findings also bring to light key environmental constraints (e.g., the need to build short-term, immediate accreditation costs into time-limited contracts that are executed within a larger slow-moving bureaucracy) and opportunities (accreditation as a potential facilitator of high-quality service delivery across organizations delivering the same EBP in a particular field).

NSTRC staff and trainer descriptions of the accreditation process

This section addresses our second research question on how stakeholders involved in on-the-ground implementation operationalized accreditation. The NSTRC initiated formal implementation site-level accreditation in 2016, after we had completed our first wave of interviews. Each site was assigned an accreditation month and specific individual at the NSTRC who would work closely with trainers throughout the process. Trainers completed a questionnaire and then participated in a follow-up interview with the NSTRC representative. The questionnaire included items such as number of active and inactive providers, coaches, and individuals trained in the past year, and client issues encountered during service delivery. During this typically 60- to 90-minute interview, questionnaire responses were reviewed with trainers, who were then asked about what was going well, challenges, and how the NSTRC could support them. Accreditation also required trainers to enter data about the organization's SafeCare program into a web-based portal. Portal data included number of active staff, monthly coaching visit completion, when staff were certified, when home visits were completed, and the fidelity scores for those visits. To be accredited, sites had to use the most up to-date SafeCare curricula and training materials. Sites also had to pay an annual fee of $1000.

Embedded within the site-level accreditation process was attainment of a new level of trainer certification maintenance that was initiated in 2017. To meet certification standards, trainers had to take part in two group calls, complete online refresher trainings, demonstrate trainer skills annually (in most cases via a video recording), and upload audio recordings so that the NSTRC could assess reliability for provider and coach fidelity ratings. Another requirement was for trainers' home agencies to pay for their participation in an annual in-person conference in Atlanta, Georgia, where the NSTRC is located. Some participants also mentioned the required use of a SafeCare trainer Facebook page.

Value to NSTRC

These next sections address our third research question on accreditation's perceived value and burden. Site-level SafeCare accreditation afforded clear benefits to the NSTRC. One primary benefit was allowing the NSTRC to both comprehensively and longitudinally track fidelity—to the intervention and the implementation process—across sites, a critical factor in EBP scale-up and ongoing quality assurance. One NSTRC staff member explained,

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"Basically, it's an implementation level of fidelity. So historically, SafeCare's fidelity has only been determined at the individual session level.... [This] does not mean on a global level they [the sites] are delivering SafeCare as prescribed." One trainer stated that prior to accreditation, the NSTRC "really didn't have the structure to make sure that the agencies continued to do it [SafeCare] to fidelity. They just had to trust that [it was being implemented with fidelity] when they trained the agency's coach or the agency's trainer." Accreditation also enabled the NSTRC to track the total number of approved sites implementing SafeCare nationally and internationally and to cultivate a community in which trainers could learn from each other, thus potentially contributing to higher quality delivery of SafeCare.

Additionally, the accreditation process provided a more streamlined way for the NSTRC to disseminate the latest information available about SafeCare, including curricula updates. Streamlining these updates and the SafeCare document versions that are distributed to clients ('materials' below) could directly affect the implementing organizations. As one HSO leader explained,

> "It makes sense that we have to stay in compliance with what National SafeCare wants us to do but I think it's kind of a challenge. There's certain things that are going to be required, like moving over to the new curriculum, which is going to be killer for us because we just did a huge mass printing of materials, and now they're saying, 'Sorry none of that's going to be any good if you want to get accredited.' So, it's like thousands of dollars of printed materials are just going to be recycled, I guess."

Other accreditation benefits for the NSTRC included "protecting the brand," celebrating and positively reinforcing sites for high-quality implementation and creating a renewable funding stream. As one NSTRC staff member explained, the fee associated with accreditation established a new source of funding for the NSTRC for activities falling outside the scope of a training contract. The fee covered costs associated with developing and administering information technology services, maintaining the portal, marketing, and developing new partnerships.

Value to human service organizations

Stakeholders across categories also suggested that the implementing organizations could benefit from site-level SafeCare accreditation. For example, the process provided an opportunity for trainers to talk to and learn from each other more frequently through trainings and the annual conference. In some cases, it created a sense of community that was not just about knowledge exchange. As one trainer explained, "It was inspiring because it was like, 'Oh, yeah. All of us are here together doing the same thing…' Because sometimes you get so isolated, just in your own little bubble." Several trainers noted that accreditation required them to look more closely at their site's internal operations. They also described being more consistent, aware, and vigilant about their conduct around SafeCare implementation as a result of accreditation requirements. Specific examples included standardizing the support that providers received (e.g., making sure it was of the same level and quality) and communicating performance expectations to staff more uniformly.

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Institutional theory posits that legitimacy is not an inherent characteristic of an organization but rather exists in the interrelationships among entities in an organizational field, including in this case, the potential consumers of SafeCare and the organizations responsible for linking potential consumers to SafeCare services. One HSO leader commented on the benefits of accreditation broadly, "It also allows us to know that we are high quality, and it allows the community to know we're high quality." Another HSO leader explained, "It solidifies the professionalism and the fidelity of the agency and the service delivery."

Multiple participants suggested that securing accreditation demonstrated legitimacy to other key members of the organizational field, namely state and county funders. For example, one trainer mentioned, "I think that makes people feel more comfortable and confident in what we're doing…. I know that [to] contractors, people who are funding us, it does matter." An NSTRC staff member echoed this idea, "In fact, [in] a lot of the systems…the agencies are utilizing their accreditation as leverage for contract renewals for service support."

Burden for human service organizations

Despite its perceived benefits, accreditation was characterized by participants as a potentially taxing process for the organizations to undertake. Several trainers described using the NSTRC online portal and tracking data to complete the annual questionnaire as time-consuming, redundant, and frustrating. An NSTRC staff member acknowledged this concern stating, "I think, honestly, that for some of them, they already have their own system, and now to double enter that information, that can be burdensome." Trainers from several sites also explained that it was difficult to comply with the videotaping requirement because of the technological demands, and a potential sense of invasiveness for families who are currently in the child welfare system and for staff who felt uncomfortable about being possibly judged.

Similar to concerns raised by the HSO and system leaders in the 2016 interviews, multiple trainers pointed to challenges associated with the accreditation cost. For example, one trainer commented, "I know a thousand dollars doesn't sound like a lot, but for a nonprofit, that absolutely is, when you don't have a steady stream coming in, to kind of cover some of these [expenses]." Another trainer described "pop-up expenses because of the accreditation process that we weren't anticipating because the accreditation wasn't one of our things written into our contract." The NSTRC waived the fee for the first year and thereafter offered sites a hardship option for those experiencing financial duress. However, the initial cost was still a problem for some HSOs that had not calculated future accreditation expenses into their current multi-year contract.

Last, although the annual conference offered positive networking opportunities, several trainers reported that the information provided at this event was not helpful in improving SafeCare delivery because the content repeated what they already knew. One trainer noted, "It wasn't that useful. It's not like I brought back a tremendous amount of insider information that transformed my practice." However, this could also reflect the fact that organizations in this study's sample already had strong SafeCare implementation policies and practices in place. One HSO leader explained, "…we found out that basically everything that is going to be required of an agency to be accredited we're already doing..."

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Impact on internal operations

A trainer and NSTRC staff member both described accreditation as a “stamp” from the NSTRC, signifying credibility for the HSOs. Two other trainers referred to accreditation as “more of a formality” and paying “a $1000 [fee] for your logo.” Regarding the logo, a different trainer mentioned, “We get this logo that we can include on our correspondence, and we get our letter of accreditation. And yeah, we can just say we’re accredited. Sounds good, I guess.” Although, as mentioned above, several trainers noted that accreditation required them to look more closely at their site’s internal operations, we found that across the trainer interviews, there were no concrete examples of how accreditation affected actual SafeCare delivery or sustainment. As one trainer stated, “Accreditation doesn’t impact the providers…. It’s what I’ve been doing for so many years, so it’s the norm for us.” These findings illustrate how accreditation may be a “ceremonial” act of inspection that helps HSOs (in a competitive service delivery market) and the NSTRC (in a competitive EBP developer and purveyor market) survive. Although site-level accreditation may symbolize an outward “stamp of approval” for both the HSOs and the NSTRC, it may also mask the true effort, quality, and complexity of the day-to-day activities that high-quality SafeCare implementation entails.

Discussion

SafeCare is an evidence-based practice that has been extensively studied, both in terms of its clinical effectiveness and its implementation and sustainment processes. This paper explores how site-level, EBP-specific accreditation can be used to implement and sustain EBPs in a human service environment (Lee et al., 2007; Lee, 2014a, 2014b; Lee et al., 2011; Lynch-Cerullo & Cooney, 2011). Modifying accreditation standards to require or encourage EBP use is an implementation strategy in the Expert Recommendations for Implementing Change compilation (Powell et al., 2015), and yet, we know little about the mechanisms by which accreditation can affect EBP implementation and sustainment in organizations (Powell et al., 2019). Our study builds upon existing accreditation-focused literature concerning HSOs and SafeCare sustainment. Findings, situated within an institutional theory framing, help to explain the pressures HSO leaders may face when deciding to get this type of accreditation and its potential effects on actual SafeCare delivery.

First, our study showed the pressures that key actors in the organizational field (i.e., the NSTRC, the implementing HSOs, and state and county-level funders) considered during the rollout of site-level SafeCare accreditation. In this study, accreditation solidified a network of SafeCare implementing agencies and the NSTRC. It concretized standards for who—at the organizational level—can provide SafeCare. Regular data monitoring and training required by accreditation also afforded implementers and NSTRC an opportunity to share and reinforce social norms around SafeCare use. These findings underscore how participating in accreditation is indicative of an HSO’s response to normative pressure.

Site-level SafeCare accreditation also promoted legitimacy to key members of the organizational field, including potential consumers of SafeCare, the organizations responsible for making referrals to SafeCare, peer organizations that shared the same client pool, and state and county entities that funded SafeCare delivery. This finding illustrated

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how participating in accreditation could be a response to mimetic pressure because it demonstrated legitimacy across the organizational field and movement toward the standards of practice in other health and public health fields (Brownson et al., 2012; Greenfield & Braithwaite, 2008).

Although SafeCare accreditation was not legally mandated, the NSTRC required accreditation as a condition of SafeCare implementation and continued use. Our findings showed how this could be viewed as a coercive pressure to which the HSO leaders were responding. More specifically, HSO leaders expressed how SafeCare accreditation could be viewed as an advantage (and perhaps an eventual requirement) when competing for contracts in their service system. Large funding streams coming out of federal initiatives like the Family First Prevention and Services Act and the Maternal, Infant and Early Childhood Home Visiting Program (Children's Bureau: An Office of the Administration for Children & Families, 2022; Health Resources & Services Administration: Maternal & Child Health, 2022) are now relying on program developers to report which sites are accredited when selecting which evidence-based programs to finance. This may push program developers to use site-level accreditation and thus increase the coercive pressure that HSO leaders face when deciding whether or not to participate in accreditation and, more broadly, which EBPs to invest in.

Second, our findings suggested that, at least initially, accreditation did not appear to substantially alter the organizational policies, processes, or activities involved in SafeCare implementation. Data tracking requirements, for example, were described as redundant by both trainers and NSTRC staff, suggesting that personnel at most organizations were already familiar with or complying with such requirements. Additionally, trainers consistently reported that accreditation did not affect SafeCare delivery or sustainment in any specific or concrete way. This finding is an example of decoupling, in this case, between the site-level accreditation status and the on-the-ground provider-level delivery of SafeCare. As described in our findings, EBP developers and HSO leaders may expect to experience other benefits outside of changes to on-the-ground EBP delivery. However, the presence of decoupling suggests that the accreditation process may need to be modified if this is to be used as a planned implementation strategy and change in on-the-ground EBP delivery and movement on key implementation outcomes (e.g., provider fidelity to the model) are the intended goals.

Towards theory-informed research on site-level, EBP-specific accreditation

More broadly, our study demonstrated how an organizational theory lens can be used to understand HSO responses to site-level, EBP specific accreditation. Institutional theory directs us to consider the organizational field and the interdependence among the actors within this field. Using the organizational field as a frame may help us better select strategies that are necessary for achieving implementation outcomes that go beyond a single organization (e.g., system wide EBP penetration or sustainment or, in the case of this study, fidelity to the implementation process across all organizations implementing SafeCare).

Furthermore, considering the organizational field and the interdependence therein could encourage program developers to incorporate accreditation into a larger, multifaceted system-level strategy package that aims to promote sustained external funding,

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implementation quality, and network weaving across organizations (Powell et al., 2015). Considering the interdependent organizational field (as opposed to each organization individually engaging in the accreditation process) could also affect how program developers design and enforce site-level, EBP specific accreditation. As this process gains traction in HSO and implementation science literature and becomes more studied as a planned implementation strategy, additional organizational theories such as transaction cost economics, agency theory, and resource dependence theory should be used to complement our study's institutional theory insights.

Practice implications: future work focused on understanding and mitigating accreditation costs for HSO leaders

Two cost-related considerations specific to the human service environment stood out in our study. First, resources are scarce, and HSO leaders may not be able to nimbly draw from other fiscal resources if unexpected accreditation expenses arise. Second, bureaucratic processes, including contract amendments and rate reimbursement changes, move slowly, which has implications for how and when accreditation requirements are communicated to and enforced with HSO and system leaders. Other questions that require future investigation if accreditation is to be used to support EBP implementation and sustainment in HSOs include measuring costs outside of the annual accreditation fee, understanding how to predict and plan for changes in accreditation costs over time, and helping HSO leaders assess and demonstrate the long-term value of this expenditure to funders. This stream of cost-focused future work should be both longitudinal and comparative; as our study showed, the point at which accreditation is rolled out can affect HSOs differently depending on if they are able to add the cost into an existing contract or not.

Limitations

Future research informed by this work can draw upon larger samples to examine how accreditation influences the implementation and scale up of other evidence-based interventions. Another study limitation relates to the timing of data collection, which occurred within the first two years of rolling out an accreditation process that was new to the developers and the trainers. Changes to organizational functioning, and perceived benefits and burdens, may be different after accreditation has become more established and routine. Additionally, it is important to note that this study only included sites that had been implementing SafeCare for many years. As a result, the study sample represented organizations and systems that were experienced, organized, and well-versed in SafeCare delivery (e.g., having their own data tracking systems). Findings may differ at sites that implemented SafeCare for a shorter period of time and were less experienced. Finally, this study only included sites located in the United States.

Conclusion

Lee (2014b, p.211) asserted that, "Accreditation has become an irresistible force in social services and mental healthcare, and it is more critical than ever to make more explicit how accreditation can improve quality of care." One way that accreditation can enhance quality care is by increasing the sustained use of evidence-based practices. Using established

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organizational theories, like institutional theory, can inform how site-level accreditation can be used as a planned implementation strategy for HSOs and improve the quality of care that clients receive.

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Declaration of Interest Statement

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Appendix 1.: Interview Guide on SafeCare Accreditation: Intervention Developers

Thank you for agreeing to take part in this interview. Today I'd like to talk to you about your knowledge of and possible experiences with agency accreditation through the National SafeCare Training and Research Center, or NSTRC. I'm interested in the decision to develop and implement SafeCare Agency Accreditation Procedures and Protocol, and your thoughts about how these new requirements might influence sustainment of SafeCare. Do you have any questions before I start the interview?

1. How does NSTRC staff typically interact with agencies that deliver SafeCare after the initial period of NSTRC training, coaching, and implementation support ends?
    a. How often is NSTRC staff in touch with agencies after the initial support period has ended?
    b. How much effort goes into maintaining contact with agencies after the initial support period?
    c. With whom at the agencies are NSTRC staff usually in contact?
    d. What is the nature of these contacts? Email correspondence? Phone calls? One-on-one meetings? Group meetings? (Probe: What typically happens during these contacts? What types of issues do you typically talk about or focus on with agency staff?)
2. What challenges impact the ability of agencies to meet SafeCare implementation standards?
    a. How pervasive are these challenges among SafeCare agencies?
    b. How does NSTRC staff work with SafeCare agencies to overcome these challenges?
3. When did the concept of agency accreditation in SafeCare first arise at NSTRC?

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    a. How did the concept gain traction over time?
    b. Who was involved in the decision to move forward with agency accreditation in SafeCare?
    c. What factors did you all consider at NSTRC when making this decision?
    d. To what extent was the decision to move forward with agency accreditation made in consultation with sites that deliver SafeCare?

4. What does the NSTRC hope to accomplish by having agencies obtain accreditation?
5. How are agencies responding to the new agency accreditation requirements?
    a. How are the trainers and coaches at these sites responding to these requirements?
    b. How are the heads of agencies responding to these requirements?
    c. How are agencies responding to the annual accreditation cost of $1000? (Probe: To what extent is this annual cost likely to cover the level of effort it will take NSTRC staff to help agencies become accredited?)
6. Can you tell me about the experience of ushering an agency through the accreditation process?
    a. What type of work is involved for NSTRC staff to get an agency through the process?
    b. What type of work is involved for agency staff to get through the process?
7. How many agencies have thus far applied for agency accreditation?
    a. What factors are agencies considering when deciding to apply as independent entities or at part of a “consortium?” (Probe: Does it matter much to NSTRC staff which decision agencies make? Why?)
    b. How many agencies have declined accreditation? (Probe: What reasons did the agencies give you for declining accreditation?)
    c. How many agencies considered “previously inactive” have sought to gain accreditation? (Probe: What has it been like to convert these agencies into an active status?)
8. Has NSTRC staff worked with agencies that did not meet accreditation standards on contingency plans? If yes: What has it been like to develop and implement these plans?
9. To what extent are agencies availing themselves of tools offered by the NSTRC to facilitate their delivery of SafeCare, like the SafeCare Portal and the updated materials?

10. From an intervention developer perspective, how satisfied are you (and the NSTRC as a whole) with the new accreditation process?

    a. What are the benefits or perks to agency accreditation? Can you explain or provide specific examples?

    b. What are the drawbacks of agency accreditation? Can you explain or provide specific examples?

    c. What might need to be changed about the accreditation process?

11. How does the accreditation requirements for SafeCare compare to the accreditation requirements for other evidence-based programs in the child welfare sector? (Probe: How about in the human services sector more broadly?)

12. In what ways will having to renew and maintain agency accreditation impact the ability of agencies to sustain SafeCare over the long haul?

    a. In what ways will it facilitate sustainment of SafeCare?

    b. It what ways will it make sustainment of SafeCare harder?

13. Is there anything else about agency accreditation in SafeCare that you would like to share?

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Appendix 2.: Interview Guide on SafeCare Accreditation: Trainer

Thank you for agreeing to take part in this interview. Today I'd like to talk to you about your thoughts about SafeCare, including changes that have occurred since you were first trained and any possible experiences that you may have had with agency accreditation through the National SafeCare Training and Research Center, or NSTRC (referring here to the SafeCare folks at Georgia State University in Atlanta). I'm interested in your interactions with the NSTRC, and in how you—as a trainer—and this agency are responding to agency accreditation requirements. I'm especially interested in how these requirements might impact future delivery of SafeCare. Do you have any questions before I start the interview?

1. When did you first become a SafeCare trainer?

2. When you have questions about SafeCare training or coaching, who do you usually contact? (Probe: How easy or hard is it to get your questions answered in a satisfactory way?)

3. Can you tell me about your interactions with the NSTRC since you became a SafeCare trainer?

    a. How often on an annual basis are you in contact with staff at the NSTRC?

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b. What is the nature of these contacts? Email correspondence? Phone calls? One-on-one meetings? Group meetings? (Probe: What typically happens during these contacts? What types of issues do you typically talk about or focus on with the NSTRC?)

c. How would you describe the quality of your communications with staff at the NSTRC?

d. How clear are deadlines and timelines assigned to you or your agency by the NSTRC? (Probe: Are you and the agency given enough time to prepare or plan for any additional requirements, meetings, changes to materials, or anything else related to SafeCare?)

4. How often on an annual basis do you need to train new staff in SafeCare?

   a. What information about the training and the trainees gets reported back to NSTRC?

   b. How has the type of information sent to NSTRC changed over time?

   c. How much of a burden is it for you to provide this information to the NSTRC?

5. How have the requirements for SafeCare changed since you became a SafeCare trainer? (*For this question, I am referring to requirements other than those focused on agency accreditation.*)

   How have the changes in SafeCare requirements impacted <u>your own SafeCare practice</u>?

   a. How have the changes in SafeCare requirements impacted <u>your ability to train or coach others</u> in SafeCare? In turn, in what ways have you modified how you train or coach others in SafeCare?

   b. How have changes in SafeCare requirements impacted <u>your agency</u>? In turn, what modifications has your agency made to comply with these requirements?

6. To what extent do you make use of tools offered by the NSTRC to facilitate delivery of SafeCare, like the SafeCare Portal and the updated materials?

7. Do you usually participate in the biannual SafeCare trainers meeting in Atlanta?

   a. When was the last time you participated in this meeting?

   b. Can you share with me your impressions of the last biannual SafeCare trainers meeting that you attended?

   c. How useful is it for you to take part in the biannual SafeCare trainers meeting? (Probe: What do you get out of going to this meeting?)

   d. How easy is it for your agency to send you to this meeting? (Probe: How are you supported financially to participate in this meeting?)

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   e. **If interviewee has yet to attend or attends infrequently:** What prevents you from going to the biannual SafeCare trainers meeting?

8. For an organization such as the one in which you work, how does the process for accrediting agencies in SafeCare work?

   a. When did you first learn about agency accreditation in SafeCare?

   b. How has your understanding of agency accreditation in SafeCare changed over time?

9. Is your agency now accredited or getting accredited in SafeCare by the NSTRC?

   a. If yes: Why did your agency decide to apply for accreditation to deliver SafeCare?

   b. Did your agency apply independently or as part of a consortium? How was this decision made?

   c. Did the NSTRC and your organization need to develop a formal contingency plan for the agency to become accredited in SafeCare? Is yes: How did this work out?

   d. If no: Why did your agency decide against applying for accreditation to deliver SafeCare?

10. What requirements does <u>your agency</u> need to follow to get this accreditation? Note: I want to distinguish between agency and trainer requirements for accreditation. (Probe: What challenges has <u>your agency</u> had in meeting these requirements?)

    a. How much work is involved in complying with the NSTRC's requirements for agency accreditation? How much work is involved in complying with NSTRC's requirements for trainer accreditation?

    b. To what extent does this agency have the administrative capacity to comply with the accreditation requirements set forth by the NSTRC? (Probe: What factors impact this capacity?)

    c. To the best of your knowledge, how does this agency balance the accreditation requirements from the NSTRC and the requirements built into the state/county service contract that funds SafeCare?

    d. To the best of your knowledge, how is the agency covering the $1000 annual cost of accreditation? (Probe: Other costs related to accreditation?)

11. In addition to what we just talked about, are there any requirements that <u>you as a trainer</u> need to follow to help secure agency accreditation in SafeCare? To help secure trainer accreditation? (Probe: What challenges have <u>you as a trainer</u> had in meeting these requirements?

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[Note: Skip Questions 12–15 based on your assessment of the interviewee's level of knowledge regarding agency issues pertinent to accreditation.]

12. How has the issue of accreditation affected the ability of the agency to deliver SafeCare?

    a. In what ways has it facilitated SafeCare delivery?

    b. It what ways has it made SafeCare delivery harder?

13. To the best of your knowledge, does accreditation in any way affect the funding that the agency gets for SafeCare? If yes: In what way was does getting or staying accredited affect agency funding for SafeCare?

14. To the best of your knowledge, how are existing service contracts or timelines/calendars for services contracts affected by the new agency accreditation requirements? (Probe: To what degree are these effects positive or negative?)

15. To the best of your knowledge, has your agency had any communications with the state/county regarding SafeCare accreditation? If yes: What issues regarding accreditation were discussed? What was the response of your colleagues at the state/county to these issues?

16. How satisfied is the agency with the accreditation process? (Note: I want to distinguish between agency and trainer requirements for accreditation. **If the agency did not seek accreditation:** What were the agency's concerns about the accreditation process?)

    a. From an agency perspective, what are the benefits or perks to agency accreditation? Can you explain or provide specific examples?

    b. From an agency perspective, what are the drawbacks of agency accreditation? Can you explain or provide specific examples?

    c. From an agency perspective, what needs to be changed about the accreditation process?

17. Have you experienced accreditation processes for other programs at this agency? If yes: How did the previous experiences with such processes compare to getting accredited in SafeCare?

18. In what ways will having to renew and maintain agency accreditation impact the ability of this organization to sustain SafeCare over the long haul?

19. Is there anything else about being a trainer, working with NSTRC, or agency accreditation in SafeCare that you would like to share?

Before we finish, is there anyone else at your agency who knows about accreditation in SafeCare with whom we should touch base?

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Appendix 3.: Interview Guide on SafeCare Accreditation: Administrators (1/30/18)

Thank you for agreeing to take part in this interview. Today I'd like to talk to you about your knowledge of and possible experiences with agency accreditation through the National SafeCare Training and Research Center, or NSTRC. I'm interested in the decision to develop and implement SafeCare Agency Accreditation Procedures and Protocol, and your thoughts about how these new requirements might influence sustainment of SafeCare. Do you have any questions before I start the interview?

1. How does NSTRC staff typically interact with agencies that deliver SafeCare after the initial period of NSTRC training, coaching, and implementation support ends?
    a. How often is NSTRC staff in touch with agencies after the initial support period has ended?
    b. How much effort goes into maintaining contact with agencies after the initial support period?
    c. With whom at the agencies are NSTRC staff usually in contact?
    d. What is the nature of these contacts? Email correspondence? Phone calls? One-on-one meetings? Group meetings? (Probe: What typically happens during these contacts? What types of issues do you typically talk about or focus on with agency staff?)
2. What challenges impact the ability of agencies to meet SafeCare implementation standards?
    a. How pervasive are these challenges among SafeCare agencies?
    b. How does NSTRC staff work with SafeCare agencies to overcome these challenges?
3. When did the concept of agency accreditation in SafeCare first arise at NSTRC?
    a. How did the concept gain traction over time?
    b. Who was involved in the decision to move forward with agency accreditation in SafeCare?
    c. What factors did you all consider at NSTRC when making this decision?
    d. To what extent was the decision to move forward with agency accreditation made in consultation with sites that deliver SafeCare?
4. What does the NSTRC hope to accomplish by having agencies obtain accreditation?
5. How are agencies responding to the new agency accreditation requirements?

a. How are the trainers and coaches at these sites responding to these requirements?

b. How are the heads of agencies responding to these requirements?

c. How are agencies responding to the annual accreditation cost of $1000? (Probe: To what extent is this annual cost likely to cover the level of effort it will take NSTRC staff to help agencies become accredited?)

6. Can you tell me about the experience of ushering an agency through the accreditation process?

   a. What type of work is involved for NSTRC staff to get an agency through the process?

   b. What type of work is involved for agency staff to get through the process?

7. How many agencies have thus far applied for agency accreditation?

   a. What factors are agencies considering when deciding to apply as independent entities or at part of a “consortium?” (Probe: Does it matter much to NSTRC staff which decision agencies make? Why?)

   b. How many agencies have declined accreditation? (Probe: What reasons did the agencies give you for declining accreditation?)

   c. How many agencies considered “previously inactive” have sought to gain accreditation? (Probe: What has it been like to convert these agencies into an active status?)

8. Has NSTRC staff worked with agencies that did not meet accreditation standards on contingency plans? If yes: What has it been like to develop and implement these plans?

9. To what extent are agencies availing themselves of tools offered by the NSTRC to facilitate their delivery of SafeCare, like the SafeCare Portal and the updated materials?

10. From an intervention developer perspective, how satisfied are you (and the NSTRC as a whole) with the new accreditation process?

    a. What are the benefits or perks to agency accreditation? Can you explain or provide specific examples?

    b. What are the drawbacks of agency accreditation? Can you explain or provide specific examples?

    c. What might need to be changed about the accreditation process?

11. How does the accreditation requirements for SafeCare compare to the accreditation requirements for other evidence-based programs in the child welfare sector? (Probe: How about in the human services sector more broadly?)

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12. In what ways will having to renew and maintain agency accreditation impact the ability of agencies to sustain SafeCare over the long haul?

    a. In what ways will it facilitate sustainment of SafeCare?

    b. It what ways will it make sustainment of SafeCare harder?

13. Is there anything else about agency accreditation in SafeCare that you would like to share?

Before we finish, is there anyone else at your agency who knows about accreditation in SafeCare with whom we should touch base?

Developed by the Southwest Center of the Pacific Institute for Research and Evaluation and the Child and Adolescent Services Research Center of the University of California, San Diego.

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Practice points:

- Current institutional pressures—such as large funding streams coming out of federal initiatives that rely on program developers to report which sites are accredited when financing evidence-based programs—may force human service organization (HSO) leaders to consider participation in site-level accreditation specific to a particular evidence-based practice (EBP) or model.
- Although accreditation may not meaningfully change day-to-day service delivery of an EBP, HSO leaders may gain other benefits, including cross-site communication and the ability to demonstrate legitimacy and competence within their organizational field.
- Accreditation cost is an essential and unavoidable consideration for program developers and purveyors who plan to use accreditation to support EBP sustainment and scale-up in HSOs.