Explaining the accreditation process from the institutional isomorphism perspective: a case study of Jordanian primary healthcare centers

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SUMMARY

Background While the main focus of accreditation initiatives has been on hospitals, the implementation of these programs is a relatively new notion among other types of healthcare facilities. Correspondingly, this study aims to understand how accreditation is perceived among primary public healthcare centers using an isomorphic institutional theory.

Design/Methodology Semi-structured, in-depth interviews were conducted with 56 healthcare professionals and administrative staff from seven non-profit healthcare centers in Jordan using an explanatory case-study approach.

Results The informants’ narratives revealed that all three components of institutional theory: coercive, mimetic, and normative pressure, were drivers for institutional change in seeking accreditation. There was an overlapping and blending between the three various types of pressure. While participants perceived that healthcare centers faced formal and informal pressures to achieve accreditation, health centers were reluctant about the time, amount of effort, and their ability to achieve the accreditation. Ambiguity and fear of failure forced them to model successful ones. Moreover, the findings revealed that normative values of health professionals enhanced institutional isomorphism and influenced the accreditation process.

Conclusion Identifying these isomorphic changes may help key stakeholders to develop plans, policies, and procedures that could improve the quality of healthcare and enhance accreditation as an organizational strategic plan. Moreover, the study provided explanations of why and how organizations move to adopt new interventions and grow over time.

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KEY WORDS: institutional theory; isomorphism; isomorphic pressures; accreditation; healthcare center

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INTRODUCTION

Accreditation is a systematic procedure in which performance of healthcare organizations is assessed against predetermined criteria and standards established by an independent professional accrediting body; it incorporates self-assessment, on-site surveys and subsequent fellowship (Accreditation Commission for Health Care (ACHC), 2015; The Joint Commission, 2015). Rather than simply maintain threshold performance standard’s level, accreditation primarily aims to enhance continuous improvement of healthcare quality through standardization of medical practice (Jaafaripooyan et al., 2011; Montagu, 2003; WHO, 2003). It improves healthcare quality by continual development of new standards, upgrading existing standards and redefining performance criteria and indicators applied to organizational structure, process and outcomes (Ng et al., 2013; Shaw et al., 2010).

Unlike licensure, the participation in accreditation initiatives does not have to be mandatory. Yet, government legislators in different countries encourage participation through the use of financial incentives, penalties and regulations. Healthcare organizations may also voluntarily seek accreditation as a marketing strategy to demonstrate quality services that meet insurance agencies’ requirements, as well as show their ability to meet and exceed patient expectations (Al Tehewy et al., 2009; Jaafaripooyan et al., 2011; Schilling et al., 2001; Valori et al., 2013).

Moreover, accreditation has also been shown to be an effective tool for organizational change (Greenfield and Braithwaite, 2008; Pomey et al., 2010) that fosters a culture of quality and patient safety across organizational boundaries (Suñol and Greenfield, 2015). Nouwens et al. (2015) added that practicing accreditation enhances team dynamics and creates a high sense of responsibility toward healthcare quality among employees.

In 2007, the Government of Jordan with the assistance of the United States Agency for International Development and in close collaboration with the WHO and other key stakeholders launched the Jordan Health Accreditation Project, as a national quality improvement strategy for healthcare. The primary aim of this project was “to reduce preventable harm in order to make patient care safer nationwide and to improve health outcomes,” with the first Jordanian hospital accredited in July 2008. The project ended in June 2013, and the accreditation program was handed to the Health Care Accreditation Council (HCAC), a nonprofit national accreditation agency (University Research Co., LLC, 2012a; University Research Co., LLC, 2012b; Health Care Accreditation Council (HCAC), 2015).

The main duty of the HCAC has been to execute professional, developmental and regulatory affairs in the accreditation process, through a wide range of quality improvement tools, approaches and activities including setting and developing standards, conducting training and education, providing consultation and survey services, measuring performance and ultimately awarding accreditation to those healthcare organizations that meet its standards (Health Care Accreditation Council (HCAC), 2015).

While the main focus of accreditation programs has been on hospital services, the scope of such programs was expanded to cover other healthcare settings including home care services, doctor’s offices and primary healthcare centers (Saleh et al.,
However, accreditation is a relatively new notion among healthcare centers (May 2011 was the first healthcare center accreditation in Jordan); as a result, the drivers and responses to accreditation programs are not clearly understood.

Institutional theory, from the discipline of organizational studies, provides a well-accepted theoretical lens to understand the emergence and implementation of accreditation programs in public health centers (DiMaggio and Powell, 1983; Meyer and Rowan, 1977; Scott, 1987; Scott, 2000; Scott, 2014). Institutional theory has been applied throughout various industries to explain how organizations move to adopt new interventions and grow over time. For example, Currie (2012) utilized the institutional isomorphism to understand the introduction of a national electronic health records system in the UK healthcare sector. Other studies have demonstrated how isomorphism pressures among similar institutions in their field, such as with higher education can lead other universities and schools to pursue similar approaches and benchmarking their standards against each other (Carolan, 2007; Dattey et al., 2014; De Lange et al., 2010; Rusch and Wilbur, 2007). These studies indicate that adopting institutional theory would therefore be an appropriate approach to try and explain the how and why public health centers are now seeking to be accredited.

**Institutional theory and isomorphism**

By blending old and new institutional theories, a “balanced institutional approach” can be proposed that institutional environments, versus technical environments, offer social recognition and support to organizations that conform with legitimate functions and cultural rules, with little concern about efficiency (Meyer and Rowan, 1977; Mick and Shay, 2014; Scott, 1987; Scott, 2014; Selznick, 1996). Within the institutional environment, there are three forms of institutional pressures that could influence organizations: regulative, normative and cultural-cognitive pressures (Scott, 2004; Scott, 2014). Through conformity to these institutional pressures and cultural expectations, organizations gain legitimacy, and this legitimacy yields access to resources and enhances survivability (DiMaggio and Powell, 1983; Suchman, 1995).

Consequently, as a response to the institutional pressures, institutions operating in the same well-established field tend to and are encouraged by their rational actors to adopt similar practices and structures. Hence, over time, the institutions become similar or isomorphic what is referred to as “homogenization” (DiMaggio and Powell, 1983; Scott, 2014; Zucker, 1987).

Institutional theorists have differentiated between three mechanisms through which institutional isomorphic changes occurs: (i) coercive isomorphism, (ii) mimetic isomorphism and (iii) normative isomorphism (DiMaggio and Powell, 1983; Scott, 2014). Coercive isomorphism results from political influences and the issue of legitimacy. It occurs when organizations have to comply with the formal requirements of more powerful institutions (i.e., government) on which they are dependent (Leiter, 2005) or to meet social expectations. Coercive pressures are also often conveyed through regulations, laws and accreditation processes. While, mimetic processes show how organizations model themselves after other
organizations became legitimate, it is a response of ambiguity and uncertainty (Leiter, 2005). Models may be diffused across organizations indirectly through employees, unintentionally or explicitly through consulting practices and associations. So when organizational innovations are not well understood, such as when goals are not clear enough or they are operating in an uncertain environment, organizations try to imitate structures and procedures of successful organizations. Institutions that are in the same industry tend to go through convergent change in order to gain legitimacy in their own environment. Last, normative pressure is associated with professionalization and triggered by shared procedural standards, methods and routines among members of an occupation. When these practices are deemed effective by professionals and experts in the field and adopted by the majority of organizations, they then became institutionalized. These three mechanisms can be overlapped in empirical settings, yet they may stem from different sources and may lead to different outcomes (DiMaggio and Powell, 1983; Mick and Shay, 2014; Scott, 2014).

There are several arguments for adopting the institutional theory as a framework to explain “why” and “how” healthcare centers are seeking accreditation. First, healthcare organizations function in a highly institutionalized environment, where governments typically regulate the procedures and practices, which could be seen as coercive (Scott, 2000). Another reason fitting more under the normative paradigm is that public health centers in Jordan are nonprofits and have similar procedural protocols and shared methods of operation because they all are part of the government health system; furthermore, as more health centers regionally tend to try and follow or duplicate other centers when they have success, the mimetic component of institutional theory can be applied. Therefore, this study specifically proposed to explain the accreditation process via institutionalization of the accreditation in healthcare organizations. Accordingly, three main theoretical propositions were developed to guide and eventually answer the main research question.

Proposition 1
Do coercive pressures enforce healthcare centers to be involved in accreditation process?

Proposition 2
Do mimetic reinforcements lead to institutional isomorphism among health centers?

Proposition 3
Do normative values of health professionals lead to institutional isomorphism?

METHODS

Study design
In order to understand the phenomenon of the accreditation process within its real-life context, an in-depth qualitative research design was adopted in the form of multiple case studies. Such design follows an interpretive paradigm, in which
researchers are not intended to test a hypothesis or examine different variables and prevalence, but to deeply understand a certain phenomenon based on the perspectives of individuals who experienced it (Creswell et al., 2007; Yin, 2009).

The case study research design is considered most appropriate when “how” or “why” questions are being posed about a contemporary set of events, over which the investigator has little or no control. Furthermore, as this study utilizes the institutional theory to explain the accreditation process, an explanatory case study design has been adopted (Yin, 2009), because it extends beyond the traditional descriptive and exploratory case studies (Fisher and Ziviani, 2004).

While there are no clear-cut rules for the number of cases, 4 to 10 cases are considered to be sufficient to reach theoretical saturation in a multiple-case study and may provide a good basis for analytical generalization (Yin, 2009). Therefore, seven accredited primary public health centers, both rural and urban, from three cities in Jordan were involved in this study.

**Participant selection**
For the purpose of this study, only administrative staff and healthcare professionals who were working in the same healthcare centers a year before the accreditation were included, so that if changes were occurring, they would have predicated knowledge, and this was the key to the research agenda. Accordingly, between seven and nine individuals from each healthcare center were voluntarily willing to take part in the study. Participants from different professions and positions within the healthcare centers were chosen as to enhance the information that could be obtained, because employees in an organization are a rich source of data serving as repositories of knowledge, experience and events (Mason, 2002).

**Interviews and data analysis**
In-depth, semi-structured face-to-face and telephone interviews were carried out between August 2014 and February 2015 at the health centers. The interviews were conducted in Arabic to enable the informants to express their ideas and perceptions more fluently and confidently. Interviewees were asked openly about how and why their organizations decided to be involved in the accreditation process and what they did to gain accreditation. They were encouraged to share their own perspectives derived from their own experiences and knowledge about the accreditation processes. Most of the interviews were conducted in the workplace; six interviews were taken in an informal way in a public place.

All interviews were audiotaped and fully transcribed, and each lasted between 40 and 60 min. Interview data were systematically coded independently by the author (M. A.) and one of the coauthors (H. H.). Open coding was conducted first, then, axial coding was carried out to flag and identify passages that helped to explain the accreditation process. Some narratives of key informants guided the research team to identify the description of codes. Once coding was completed, we discussed all coded at a deeper interpretive level in team meetings, thereby organizing the emerging ideas into themes and subthemes to establish patterns and form a more precise and complete explanation.
As an analytic strategy, we followed the three theoretical propositions. This helped us to focus our attention on more relevant data and to organize our themes and subthemes. Finally, an explanation building in narrative form was utilized as an analytical technique (Yin, 2009).

The analysis was conducted in parallel with data collection, this assisted in exploring and explaining emerged issues and ideas. To strengthen the internal validity, interviews were repeatedly read and analyzed using an iterative approach. A combination of hand-coding and ATLAS-TI software were employed in the data analysis. Quotations used were translated by a person who was not involved in the study.

**Ethical approval**

Ethical approval was requested and granted by the Institutional Review Board at Jordan University of Science and Technology and the Jordan Ministry of Health (MoH).

**RESULTS**

Fifty-six informants with different internal vocations and responsibilities and various levels of seniority participated in the study (27 were men and 29 women). Their years of experience ranged from 4 to 30 years, with an average of 16 years. According to their professions, 6 were physicians, 4 were dentists, 18 were nurses/midwives, 16 were from other allied health professionals and another 12 were administrative staff. Six of the physicians, one dentist, seven nurses and two from other health professionals also had administrative duties (Table A1).

Findings from the analysis of the interviewees’ narratives evolved around the following themes. However, there was no clear distinction between the three isomorphic pressures.

**Being among the first accredited centers**

Two of the health centers were proud of being among the first health centers in Jordan to be accredited (12 September 2012). The centers saw themselves as leading exemplars to which other centers should aspire. A manager of one of these centers stated that

“Our center was and still one of the best centers in this region, even before accreditation. We were very confident that we can achieve accreditation. When we became accredited this of course proved that we are a good example of what a health center should be.” (HC3.D1)

The head nurse in the second accredited center shared the same opinion.

“This health center is always in the top. We are doing very well, with or without accreditation…why till now many health centers are not accredited yet? Because even we are providing similar services for patients, we are not same.” (HC6.N2)

However, even though they were proud of being among the first accredited centers, the pressure exerted from the government on these two facilities was apparent.
“Why we have gone through accreditation? I can simply say because the head of the Health Directorate, told me ‘you are an excellent health center, in terms of services provided, management and other things, you have to go through the accreditation, I have confidence that you can attain it.’” (HC6.D1)

This led us to the next theme:

*Indirect political influence exerted by the government*

Although all health centers included in the current study are fully government funded and managed through the MoH in terms of formulating the strategic plans, recruiting staff and providing and allocating resources, informants stated that there was no direct or explicit pressure from the MoH on centers to achieve accreditation.

“The government doesn’t compel us to gain accreditation, they don’t come to you and say this center must have the accreditation; otherwise you will get a penalty.” (HC5.A1)

Yet, they believe that the MoH indirectly pushed them toward accreditation process. The same administrative staff added

“But what the ministry actually does, they prominently advertises accredited centers on the ministry web-site, in public media, and elsewhere. By doing this they sending us a message, if you don’t achieve accreditation now, you will have to at some point in the future.” (HC5.A1)

A physician in another center shared the same opinion.

“The government is not going to punish us if we were not accredited…In fact, what the government does implicitly, when the Minister of Health appears on the TV and says: Those health centers have successfully achieved accreditation, and he starts talking about the benefits of accreditation, he is indirectly saying, eventually all health centers should be accredited.” (HC7.D2)

*The need for legislation and cultural expectations*

Other external pressures that induced health centers to seek accreditation were legislation and societal expectations, because the accreditation process was seen as a way to demonstrate that the health center was one that provided good quality care; it added value to society. There was a common theme expressed by the informants that being an accredited health center was seen to enhance the status of the center and the perceptions of local community members.

“People around us now, after accreditation, see us in a better light. You know what does that mean? That means they are happy and satisfied with the care we provide.” (HC2.D1)

“In this center we serve our friends, our relatives, and our neighbors…People know each other, and people now say very good or excellent things about us as
a health center, since we received our accreditation. That does not mean we were bad before but now they see us in a better light”. (HC3.A2)

Informants believed that healthcare centers intended to meet social needs and mitigate social suffering. This view was particularly prevalent among participants from health centers in rural areas.

“We are just a local community healthcare institution, our main goal is to serve our community needs and relieve their suffering, and this is the only close place where people can get medical services.” (HC4.A1)

However, the interviews highlighted the importance of accreditation as health centers attempt to meet the needs and expectations of local communities.

“Needs and expectations of our patients are changing rapidly from what they were in the past, this put more pressure on us, and considered as a challenge for the healthcare sector in Jordan as a whole. I think the ultimate goal of accreditation is to ensure that we are serving our patients according to their needs and expectations and this in turn will improve the health status of communities.” (HC3.N3)

Although many patients were not fully aware of what the accreditation meant, they became more confident about the services provided, and in turn, the health centers used this status to improve their image. This was apparent from interviews conducted with those at health centers that had recently achieved accreditation. And although the health centers in the study were public institutions and did not see themselves as competitors, they all wanted to market themselves socially among their communities.

“Many times a patient comes to my office and asks me what does accreditation mean and why do you need accreditation. I tell them about accreditation and what are the benefits of the accreditation on health quality, patient safety, and general services. When the patients know about its benefits, they see our services as good services, and this in turn is a benefit for our center.” (HC7.N2)

“I want my patients, their relatives, and all people in this community see this health center as the best. This center is for our people, we serve them, and they should be happy with us, with services which we provide.” (HC6.D1)

However, some of the informants shared their feelings and were reluctant about the impact accreditation actually made on quality improvement, while others felt that accreditation had a positive impact on their quality of care and services. They had divergent views about its effectiveness and efficiency; most believed that the accreditation process increased reporting requirements both internally and externally, as well as increased the documentation process.

“We now have many policies. We have policies for every department. We do a lot of documentation, and I’m not sure if accreditation is effective, or if it improves the quality, as well as the costs of the process itself.” (HC7.HCA2)
Contrary to this view, a healthcare assistant stated that

“Accreditation improved many thing in this center, the laboratory, x-ray department, the pharmacy, everything. Patients’ satisfaction, patient privacy, everything improved because of the standards and accreditation.” (HC2.HCA3)

During preparations for accreditation, health centers tried to make sure that their structures, policies and procedures conformed to the HCAC requirements.

“We did what they (the HCAC) wanted from us exactly. We did not have time to design a new structure or make other revisions, we adopted the structure, policies, and procedures that complied with the HCAC standards, otherwise we would have failed.” (HC1.D1)

By achieving accreditation, some of the healthcare centers saw it as a way to gain prestige and recognition with the MoH.

“The Ministry of Health doesn’t give financial incentives to accredited centers, but, once your center is accredited, the Minister announces the achievement through our public media and press. This in turn, has some kind of prestige for what you have done.” (HC3.N2)

Peer evaluations and site visits whereby the health centers performance was measured against process and outcomes indicators were seen as another informal source of influence, especially among physicians and nurses.

“As a nurse, I want to be seen by other nurses as a very good nurse. I know that the accreditation committees include nurses and other healthcare staff who are evaluating the nursing services. If you don’t hit their benchmark, I think they will not see you as a good nurse.” (HC7.N2)

Mimetic pressures

Participants from various health centers narrated different reasons for seeking accreditation, but some were influenced by other healthcare centers having been accredited.

“We are primary health centers working under the same directorate. The directorate is an umbrella for all of us, so when the first center was accredited, this encouraged other centers to start think seriously about accreditation.” (HC7.D2)

Some of the healthcare centers held the opinion that seeking accreditation would be difficult because this was a new concept and new process and they feared failure. Because of these concerns, health centers starting the accreditation process reached out to other centers that had successfully completed the process, to learn about accreditation process and in hopes of adopting some of their practices and activities to ensure they would achieve accreditation. In doing so, health centers were benchmarking themselves against accredited centers.

“My manager and I visited two accredited centers before we started contemplating our agency’s possibility of going through the accreditation process, we wanted
to understand and know how they were complying with the standards, and which areas were most important to focus on. We did visits to know what were the important aspects HCAC would be looking for?” (HC2.N1)

“I know that ‘Health Center X’ is the best in this directorate…They provided comprehensive primary healthcare services, even before the accreditation, I went there and had a chat with the manager of that center, because I knew that center was the best.” (HC5.D1)

Conversely, some informants expressed clearly that instead of following high-performing centers or those who had a good reputation in providing high-quality services, they looked at those who just passed the accreditation. This was especially evident because the tangible benefits of the accreditation could not be easily traced and quantified.

“It’s very difficult to assess the impact of the accreditation on healthcare sector, at least it’s still early. We don’t know whether those centers who have a good reputation can be attributed to accreditation or not, because they were good centers before accreditation. Before we made a decision to achieve accreditation, we were looking for those nearby centers who had just received their accreditation evaluation.” (HC4.N2)

Participants across all the centers expressed a deep concern about staff shortages, motivation and the resources needed.

“There were staff shortages, here in the pharmacy and other departments, we got a new pharmacist before we started accreditation but this was not enough, we had shortages in many areas.” (HC5.HCA1)

“There were no external motivators for accreditation, even non-financial incentives, to help employees buy into the accreditation process, we spent long working hours preparing for accreditation. This work deserves some sort of a ward and respect.” (HC7.N1)

For some health centers, mimicking the approach of other healthcare centers to obtain accreditation was a way to mitigate the feeling of uncertainty. By duplicating what they had been through, it serves as a way to minimize the effort and time necessary to go through the accreditation. This in turn pushed some centers to pursuing a “shortcut” approach rather than following the best practices of other centers.

“We imitated other centers, frankly we did what others did. We didn’t have time to do everything from the scratch, we don’t have the infrastructure that could help us. Accreditation was something new for us.” (HC7.HCA1)

“We have shortage in staff, especially healthcare professionals, shortage in resources, in financial resources, and with equipment. With all these shortages, the government asks you to achieve accreditation? So, as health centers, they start practicing the “short-cut” methods to achieve the accreditation, you can’t do that, ideally.” (HC2.N2)
Health centers wanted to make sure that their healthcare facility did not fall behind, so being part of the accreditation process along with other centers was another driver for many of them.

“We had a meeting for the all staff here, our manger said listen to me ‘may be you have heard about accreditation, and many health centers in the Kingdom are achieving it, and we have to. I’m not going to force you to participate, but this is our health center, we don’t want to be in the bottom.’” (HC4.N2)

Interestingly, as more and more health centers achieved accreditation, the legitimacy of the accreditation process was validated, and a perception that nonaccredited centers were less legitimate began to take hold.

“At the beginning when accreditation first came, health centers who achieved accreditation at that time were seen as leading centers. Now it’s different, if you are not accredited, everybody, I mean the patients, the ministry, even the local community will see you as an unable to provide good services.” (HC1.HCA2)

Normative pressures

The interviews identified several normative mechanisms that influenced health centers to seek accreditation. However, the most prominent shared theme was an increasing awareness and a changing perception of the importance in accreditation, as being accredited was a way of assuring quality of care and standards and local community members became involved in accreditation process.

“As local community members started to understand the importance and what accreditation was, we had to deal with this. We collaborated with them and there was coordination with the local community institutions. Our accreditation committee included people from the local community, they were important stakeholders in the process.” (HC4.N2)

“...one of the reasons why we moved towards accreditation was recognition from our local society, we knew that accreditation provided them the evidence that we are able to offer high quality services based on high standards and we are able to do that.” (HC3.HCA1)

There was a common sense among participants that accreditation also enhanced networking opportunities. Instead of working in an isolated environment, collaboration and being a member of peer group became apparent, especially among those who were late adopters. Professional networking was enhanced through shared training programs and workshops that were offered by the MoH and HCAC for all health center staff. Such programs were very helpful not just to gain accreditation but to improve staff knowledge and standardize services.

“As a response of accreditation process, we built a network with other centers to share ideas and this continued even after we received our accreditation.” (HC1.N2)
“The health directorate offered all the health centers going through the accreditation process various training programs. We met other colleagues from other health centers. We built good relationships with them.” (HC3.A1)

“We participated in training programs which were managed and offered by the HCAC, programs were about not just regarding standards, for example they provided a training program about CPR (Cardio-Pulmonary Resuscitation).” (HC5.D1)

The HCAC also made recommendations as to best practices and guidelines for health centers that were trying to secure accreditation credentials and standards that would need to be continued after the accreditation. These recommended practices and guidelines from the HCAC along with the training programs created a sense of what they called accreditation culture. Accreditation culture was based on the participant’s narratives where they had embraced technical terms and phrases such as policies, procedures, standards and quality as it related to accreditation.

“One of the benefits that I have found from the HCAC guidelines and training programs was the accreditation culture. Now, I know what the meaning of accreditation is and how that is related to policies, procedures, standards. This culture was adopted by myself and my colleagues.” (HC2.N2)

DISCUSSION

The depth of disclosures and discussion by the participants at these healthcare centers clearly demonstrates isomorphic change, where coercive, mimetic and normative pressures on the organizational field of healthcare lead to institutional change. Furthermore, their comments show how there was overlapping and blending between the three various types of pressure.

Based on their narratives, healthcare professionals and administrative staff perceived that the health centers had no choice but to respond as best as they could to the pressures exerted by both the government and their local communities. The government power mostly was derived from the institutional dependence of these nonprofit healthcare agencies on the government (Leiter, 2005). It has been argued that institutional pressures are less effective on for-profit organizations than nonprofit and governmental institutions, because the later are more sensitive to institutional and legitimate influences, as they do not have explicit performance indicators resulting from sales and profit margins (Frumkin and Galaskiewicz, 2004). Hence, the dependency of health centers on government funding and other resources made them more vulnerable to implicit coercive pressures. A possible reason why health centers did not receive explicit pressure from the MoH as a powerful institution is that the ministry recognized that not all health centers were ready for accreditation in terms of human resources, employees’ motivation and organizational culture. Coercive pressure further stemmed from rules, regulations and processes of the HCAC. The accreditation agency (i.e., HCAC) might reshape healthcare settings in terms of structure, policies and procedures (Lanteigne and
Bouchard, 2015; Saleh et al., 2014), as health centers try to design/redesign in a way that help them achieve accreditation and certification. Moreover, these health centers faced informal, but heavy, pressures to achieve accreditation, including gaining legitimacy, improving their image and the process of the peer review. These findings are consistent with the first proposition stated that “coercive pressures forced healthcare centers to get involved in accreditation process.”

While participants in the study felt coercive pressures, most agreed that there was definitely a debate about going for accreditation or not, as healthcare center employees were reluctant about the time, amount of effort and their ability to achieve the accreditation. Therefore, ambiguity and fear of failure forced health centers to imitate the successful and legitimated centers through observing and learning processes in order to become accredited and legitimized too, thus producing institutional isomorphism. This lends credence to the supposition that when nonprofit organizations face generic issues, there will be a tendency toward similar solutions (Leiter, 2008). This in turn led to some facilities employing benchmarking activities to achieve accreditation, even though many health center employees were skeptical about the tangible benefits of accreditation that focuses more on policies and procedures. Being accredited and legitimized pushed health centers to follow approaches of high-performing accredited health centers. However, accreditation in the primary care sector is generally seen as a tool for assessing and benchmarking the performances of healthcare settings across a wide range of clinical and organizational domains (Lester et al., 2012; Pomey et al., 2010; Rajan et al., 2015). On the other hand, uncertainty and limited resources encouraged health centers to practice “shortcut” approaches. This implies that accreditation programs that pretend to improve the quality of healthcare might lead to dysfunctional consequences. These findings fully support the second proposition that “mimetic reinforcements lead to institutional isomorphism among health centers.”

Interestingly, none of the health centers undertook their own evaluation and analysis before going through the accreditation process; instead, they followed the other approaches of accredited centers. This could be explained by the “bandwagon effect” (Abrahamson and Rosenkopf, 1993); as more health centers became accredited and legitimized, there was a concern among nonaccredited centers of lagging behind and losing of legitimacy; therefore, they trusted other accredited centers just because they had attained the accreditation.

These findings also support the notion of the institutional adaptation perspective, which argues that in order to achieve or maintain legitimacy, institutional actors should comply to beliefs, norms and rules of the institutional environment (Van de Ven and Hargrave, 2004). These practices were clearly driven by the need to achieve accreditation and are in part of normative pressures of isomorphism as defined by DiMaggio and Powell (1983). Normative isomorphism is strongly embedded in healthcare setting, in the sense that clinicians such as physicians, nurses and various allied health technicians have completed their academic degrees and obtained profession licensure and are practicing the same skills (Greenwood et al., 2002; Scott, 2000). Other examples of normative pressures seen in health field and influencing the accreditation process are professional networks, collaborations, trainings and workshops provided by professional bodies including but not limited to
governmental and accrediting agencies. In addition, accrediting agencies play a significant role in fostering organizational culture and in establishing consistency as to organizational practices used to achieve accreditation. These agencies are considered normative isomorphism agents because they embody professional standards through their guidelines and practices at the institutional level or within the institutional environment. This is consistent with previous studies from different disciplines including higher education (Hodge, 2010; Johnston, 2013) and nonprofit public sector organizations (Frumkin and Galaskiewicz, 2004).

Finally, the qualitative analysis revealed that healthcare professionals involved in the accreditation process started using common terms and phrases related to the process. This adoption of terminology reflects a degree of acceptance as language plays a vital role in creating a new organizational culture (Alvesson, 2011). Consequently, it appears that the third proposition that “normative values of health professionals lead to institutional isomorphism” is supported.

Recommendations and policy implications

Coercive pressures with limited resources can be a detriment to innovation and encourage dysfunctional consequences, such as “shortcut” approaches. This makes it imperative to carefully observe such activities because they negatively affect quality improvement and performance levels of health organizations, especially in the long run.

However, none of the health centers described accreditation as an organizational strategy to improve their quality; instead, they focused on how they planned to achieve it. The findings provide clear evidence for the notion that public health centers are seeking accreditation to gain legitimacy and build a reputation, rather than improve quality and safety. This is in direct contrast to the goal of accrediting bodies, such as HCAC, whose goal is to assure quality and standards. As such, nonprofit health institutions might attempt to secure pragmatic legitimacy (Suchman, 1995), which means institutions try to satisfy an individual or public interest rather than efficiency and effectiveness (Suchman, 1995; Thomas and Lamm, 2012). Stakeholders and policymakers must attend to the fact that these organizational practices are not effective and they should carefully monitor such practices to improve actual organizational performance, not just for gaining legitimacy. This may be better controlled by conducting frequent unannounced site visits; paying more attention to outcomes performance measures, not just process and structure measures; and utilizing financial and nonfinancial incentives and enhancing the organizational culture to better assure continues quality improvement.

The findings also indicate there is a need to raise the awareness and change the attitudes of healthcare professionals about the potential benefits of accreditation, in order to address their skepticism. Moreover, understanding whether organizational change is isomorphic is important for policymakers and accreditation agencies so that they may identify policies, procedures and practices that are likely to become institutionalized over time. Identifying isomorphic changes help key stakeholders set up policies and procedures that could improve the quality of health services and enhance accreditation programs as an organizational strategy.
CONCLUSION

Although institutional theory has been applied throughout various sectors to explain how and why organizations adopt new interventions and grow over time, this in-depth qualitative study is foremost to explain the accreditation process among non-profit healthcare centers using isomorphic pressures. Nonprofit health centers are in fact vulnerable to all three types of institutional forces (coercive, mimetic and normative). While the institutionalized environment is one that places influential forces on institutions toward the accreditation process thus being coercive in nature, in the local health sector, there is an inexorable potential force toward homogenization. Institutional theory provides a very useful insight into why and how healthcare organizations are seeking accreditation, and the findings can be used to understand organizational strategic change overtime. However, the results of study raise a number of questions and ideas for further research. First, there is the need to explore the intersection between innovative and isomorphic change and the impact of isomorphism and organizational strategy. Future research should also examine other factors that could impact on how an organization responds to the institutional environment including organizational characteristics such as size, leadership style and performance, and the status of the institution’s reference group. Last, duplication of this study in hospital settings and among for-profit healthcare organizations should be conducted to determine if these findings are generalizable to other types of healthcare settings and whether organizational culture has an influence on institutional change.

ACKNOWLEDGEMENTS

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CONFLICT OF INTEREST

The authors have no competing interests.

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USING THE INSTITUTIONAL THEORY TO EXPLAIN ACCREDITATION PROCESS


APPENDIX

Table A1. The characteristics of informants

<table>
<thead>
<tr>
<th>No.</th>
<th>Informants</th>
<th>Gender</th>
<th>Professions</th>
<th>Status in practice</th>
<th>Experiences in health sector/years</th>
<th>Experiences in health care</th>
<th>Years in current practice</th>
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</thead>
<tbody>
<tr>
<td>1</td>
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<td>Male</td>
<td>Physician</td>
<td>Health center 1 Family doctor/health center manager</td>
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<td>2</td>
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(Continues)

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<th>No.</th>
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<th>Gender</th>
<th>Professions</th>
<th>Status in practice</th>
<th>Experiences in health sector/years</th>
<th>Experiences in health care</th>
<th>Years in current practice</th>
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<td>Nurse</td>
<td>Registered nurse/ head nurse</td>
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</table>

(Continued)

| 1   | HC2.N1     | Female | Nurse               | Head nurse                          | 24                                | 10                        | 10                      |
| 2   | HC2.N2     | Female | Nurse               | Healthcare assistant                | 15                                | 4                         | 4                       |
| 3   | HC2.N2     | Female | Nurse               | Practical nurse                     | 25                                | 23                        | 23                      |
| 4   | HC2.D1     | Male   | Physician           | Family doctor/ health center manager| 22                                | 5                         | 5                       |
| 5   | HC2.A1     | Male   | Admin               | Medical record technician           | 11                                | 6                         | 6                       |
| 6   | HC2.A1     | Male   | HCA                 | Healthcare assistant                | 28                                | 23                        | 23                      |
| 1   | HC3.N1     | Female | Nurse               | Midwife                             | 28                                | 20                        | 20                      |
| 2   | HC3.A1     | Female | Admin               | Medical record technician           | 12                                | 6                         | 6                       |
| 3   | HC3.D1     | Male   | Physician           | Family doctor/ health center manager| 29                                | 20                        | 20                      |
| 4   | HC3.A1     | Male   | HCA                 | Healthcare assistant                | 10                                | 8                         | 8                       |
| 5   | HC3.A2     | Female | Admin               | Bureau chief                        | 21                                | 5                         | 5                       |
| 6   | HC3.D2     | Male   | Dentist             | Dentist                             | 18                                | 4                         | 4                       |
| 7   | HC3.D2     | Male   | HCA                 | Healthcare assistant                | 5                                  | 5                         | 5                       |
| 8   | HC3.A2     | Male   | HCA                 | Medical record technician           | 25                                | 22                        | 22                      |
| 9   | HC3.N3     | Female | Nurse               | Registered nurse/ head nurse        | 9                                  | 4                         | 4                       |

(Continues)
### Table A1. (Continued)

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