What International Providers Can Teach the U.S. About Accreditation

By Michael W. Johnson, Managing Director of Behavioral Health, CARF International

I spend around 180 days each year traveling in the United States and internationally. The primary purpose of my travel is to help people understand what value accreditation can bring to their organization.

The conversations I have with providers are often unique (and complicated), and vary depending on the particular economic and regulatory pressures or competitive environment of each organization. But I have noticed a difference in these discussions with providers in the United States compared with those in other countries.

In the United States, many behavioral health organizations are looking at accreditation due to some sort of regulatory or payer pressure. They often feel forced to become accredited and, from time-to-time, they seem angry and resentful for this added level of accountability. Internationally, however, discussions center more frequently on accreditation as a tool for providing services of the highest quality.

Keep in mind that behavioral health organizations outside the United States often don't have the regulatory or financial incentives pushing them to become accredited that many do in the U.S. I am not trying to diminish those things. You have to operate legally within the licensing requirements of your jurisdiction and get paid in order to be in business. But I believe incentives and requirements for accreditation can sometimes obscure its value.

After all, what distinguishes a successful provider from an unsuccessful one if they both operate in the same regulatory and financial environment? I think the answer is how each is managed, and where they place the value of the persons they serve. If you do those things right, which accreditation can help with, you are more likely to be successful and also address regulatory and payer requirements.

International providers, who have fewer outside pressures, help remind us of this fact.

Regulatory and payer incentives

Because it seems many organizations in the U.S. are first introduced to accreditation by regulatory or payer incentives, I'd like to address those quickly. Incentives can take a couple of forms. The main versions include:

Mandates

- Many states have mandates that require behavioral health organizations to be accredited to participate in Medicaid or to become licensed. In these states, the decision to become accredited is not complicated. It is a cost of entry into the business.

Deemed status

- Some states have incentives such as deemed status. This presents a choice for an organization to become accredited in lieu of a licensure visit from the state. I often speak to organizations in this situation that are searching for an additional incentive beyond just licensure to help push them toward accreditation. Sometimes the deemed status is enough for them to consider moving toward accreditation, but many times it's not.

Insurance reimbursement

- In the substance use disorder treatment marketplace, many commercial insurance companies such as Aetna, Cigna, and United Health Group require accreditation for reimbursement. Often, organizations are motivated to seek an accrediting body to access certain payments.

The regulatory and insurance environments are becoming even more complicated. In much of the healthcare marketplace, independent practitioners are getting "squeezed out" and having to work in groups or independent practice associations in order to survive under increasing cost pressures. When providers join a group and share a patient population, they often face different regulatory and reimbursement complexities.

Many of the commercial insurance companies are still trying to determine who their "high value" providers are. They are creating special contracts with providers who meet certain outcomes that result in less utilization management and potentially better rates. Insurers are still in the early stages of determining the criteria for these contracts, but unquestionably being accredited is a cornerstone.

Despite all this, the best argument for accreditation is not about regulations, requirements, or getting paid.

If not outside incentives, then why accreditation?

At the end of the day, accreditation is a quality improvement activity designed to improve care to persons served. Accreditation alone does not ensure improved outcomes, but it provides a framework for organizations to be accountable and responsive to persons served and their families.

I worked in accredited organizations for many years, was an accreditation surveyor, and now work for an accrediting body. So I believe in the value of accreditation as a means to improve quality, and I'm not unbiased about that. If you work in an unaccredited organization, I am not trying to imply you do not provide a quality service. But quality is not a static dimension.

Once you achieve a certain level of quality, you can continuously push further. I frequently hear from organizations after they have been accredited for a while that they didn't know what they didn't know. They didn't anticipate that becoming accredited would result in the overall organizational improvement that it did.

I often use my conversations with international organizations as anecdotes when I speak to people considering accreditation in the U.S. International providers talk about their pride in the accomplishment of meeting high standards of care. And they are open about how that translates into value for the persons they serve.

Approaching accreditation for the reason of quality improvement and rallying an organization around this cause results in improved outcomes. This is not only good for the persons you serve, but also for business sustainability. International providers understand this and pursue accreditation as a tool toward that goal, even without external incentive.

U.S. organizations also can (and frequently do) approach accreditation in this way because they have the same interest in providing quality services. Ultimately, implementing practices aimed at being accountable to the persons you serve and your own outcomes naturally addresses what regulators and payers are looking for as well.

Michael W. Johnson joined CARF as managing director of the Behavioral Health accreditation area in 2013. A certified addictions professional, Johnson has more than 30 years of experience as a clinician, manager, and executive working in mental health, substance abuse, and intellectual disabilities fields. He was a CARF surveyor for 16 years and holds a master's degree in communications from the University of Central Florida.