Accreditation: the First Layer of the Quality Floor

by Ruth Carol

Employers find data valuable, but still seek other measures. In this article, experts assess the uneasy relationship between the business community, healthcare organizations, and accreditation.

Stirring in the healthcare arena is an alphabet soup of accrediting bodies. There's the National Committee for Quality Assurance (NCQA), the American Accreditation Healthcare Commission, formerly the Utilization Review Accreditation Commission (URAC), and the Joint Commission on Accreditation of Healthcare Organizations, to name a few. And the pot is growing more crowded with the International Organization for Standardization (ISO) recently entering this sector.

While these accrediting agencies may target different types of organizations with some degree of overlap, their goal is the same: to ensure that health plans and institutions are meeting standards that suggest they are delivering quality care.

An important audience for this message is the business community—the employers and self-insured parties who comprise the second largest group of payers (after the US government). But does the business community see value in accreditation? Do they equate it with quality? And finally, are employers using data and information from accrediting agencies to evaluate health plans and institutions?

The answer to all of these questions is "yes"—in varying degrees.

Keeping a Watchful Eye

"Accreditation is one of the essential elements showing accountability on the part of health plans and providers," notes Suzanne Delbanco, executive director of the Leapfrog Group, a Washington, DC-based organization founded by Fortune 500 companies and other large healthcare purchasers that aims to use employer purchasing power to initiate improvements in the safety and value of healthcare.

"They also use accreditation as a vehicle for quality improvement. By meeting consistent measures and reporting the results, it enables plans and providers, as well as purchasers to get a handle on where quality needs to be improved," Delbanco says.

Many believe that accreditation serves as the foundation on which quality is based by setting standards for health plans and providers to either meet or be excluded. Quality improvement is really central to the notion of accreditation, according to Jim Mortimer, president of the Chicago-based Midwest Business Group on Health (MBGH). "By targeting problems, such as misuse and overuse of care, quality can be improved and costs reduced. Accreditation is a floor underneath that."

David Lansky, president of the Foundation for Accountability (FACCT) in Portland, OR, contends that the majority of business leaders believe it's important that accrediting bodies keep a watchful eye on healthcare organizations. But for the most part, he says, they are unfamiliar with the process. "Then there is a group of leaders who give accreditation more credit than it deserves because they believe there's more thoroughness in the process as it pertains to quality than there really is," he says. "A third small group of informed business leaders have a pretty clear idea about the role of accreditation. They would say, in general, that accreditation is an important, minimal requirement that assures them that the basic functions of a healthcare organization arebeing properly executed."

Lansky believes that knowing an organization has passed these minimal standards doesn't automatically mean it is providing quality care. "It's one piece of data among many others that purchasers want to look at," says Lansky. "But it's not a definitive signal about the quality of care being provided."

According to the Joint Commission, however, accreditation provides a good deal of assurance. "Accreditation provides an employer with the assurance that the organization has made a commitment to performance improvement," says Gina Zimmerman, the Joint Commission's senior executive director of business development and executive director of network accreditation. Furthermore, she maintains that the scope of the organization's accreditation process for managed care organizations incorporates a review of care delivery sites, such as hospitals and home care organizations, reassuring employers that the evaluation process addresses sites where employees actually receive care.

While some businesses only want to know if an organization is accredited or not, others will only contract with accredited health plans that work with accredited institutions. Just how much importance business leaders place on accreditation seems to depend largely on the size of the employer.

"Some employers don't find accreditation particularly important and are more interested in financial and other aspects of the offering," says Tony Kotin, a principal in the health and group benefits practice of William M. Mercer's Chicago office. "And some employers, as part of their selection process, mandate that a health plan must be accredited if they offer it. Generally speaking, the larger employers with dedicated benefits staff tend to be much more interested in accreditation, quality, and performance issues. As the employers get smaller, they're much more focused on other aspects because they don't have either the staff or the time to spend on these issues.

Who Has the Most Credibility?

The value of accreditation also depends on the accrediting body wielding it. The NCQA has a lot of credibility among business leaders, in part, because it was designed with employer input, Lansky says. "As such, it reflects the things employers care about more directly." Because NCQA uses a combination of meeting standards through its accreditation field surveys and publishing performance data via the Health Plan Employer Data and Information Set (HEDIS) measures, Lansky says it is considered a demanding system.

NCQA is considered the "gold standard" for determining whether a health plan can meet certain standards of quality because its leadership since 1991, the year it became established as an independent organization, has been large employer representatives, according to Barbara McMahon, a consultant in the health management practice division out of Hewitt Associates' Rowayton, CT, office.

Likewise, employers recognize the Joint Commission as the accrediting agency for hospitals. "They look at the managed care organization to see that it has NCQA accreditation," says McMahon. "And they look at the managed care organization in terms of what percentage of hospitals in its network has Joint Commission approval." Although many employers know that the Joint Commission ventured into the network market a few years ago, she says, they also know that it's a relatively new accreditation program and few networks have gone through it to date.

URAC, which accredits health plans—predominantly preferred provider networks—and certain functions within the organization, such as case management and physician credentialing, is less familiar to employers. Those who do know it say URAC is considered an effective player in the accreditation arena.

The latest organization to join the accrediting pack is ISO, which published its voluntary guidelines for the design of process-based quality management systems for the healthcare sector in September 2001. Introducing ISO 9000 quality management systems into the healthcare arena is just another example of business practices being brought into the fold, says Leapfrog's Delbanco. The guidelines are not specifically intended for accreditation purposes. However, some employers are excited about the prospect of using these new measures, Delbanco says.

Not Without Caveats

Probably the single biggest criticism of the overall accreditation process is that accrediting agencies are paid by health plans and institutions being reviewed. As Delbanco questions, "How far can accreditors push those they accredit before they risk some backlash?"

Another criticism is that accreditation could be tougher. MBGH's Mortimer, who serves on a Joint Commission patient safety work group, cites the agency's patient safety standards implemented in 2000 as an example of standards that could be even

more aggressive. Among other things, these standards call for organizational accountability for an internal medical error prevention program targeting at least one high-risk process each year. “Why not make it a quarterly activity or the ‘top 10’ errors per year?” he asks.

Lansky concurs. “There’s a frustration about what we can do to raise the bar and move the performance level up.” While accreditation is the groundwork for setting standards, a performance information system is necessary to inform employers how well their employees are being cared for, he says. “We hear from a lot of purchasers that the bottom line is whether their employees are healthy, have a positive state of mind, and can perform well at their jobs. That’s what they think they’re spending all of this money on their healthcare for. But they haven’t had much support by the healthcare system to measure and report inthose terms.”

Data Employers Can Use?

The argument that accreditation-driven data does not drill down to information employers really want echoes throughout the business community. In fact, it’s the main objective behind the formation three years ago of the V8, a group of coalitions in the National Business Coalition on Health (NBCH). Both the NCQA and the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) have assisted the group in developing common health plan specifications and criteria that can be executed across communities.

The V8’s goal is to standardize a request for information and relate it to the request for proposals that coalitions and employers use each year to measure how health plans perform in specific areas, explains Mortimer, who serves on the V8. Much of the information focuses on disease management; for example, what kinds of programs are offered, how they are structured, and how their results are measured.

The standardization of this information not only enables employers to compile and analyze comparable health plan performance information geographically, it provides them with information that was previously unavailable.

“Instead of just indicating that a plan is accredited, this document gives a breakdown of its status,” explains Catherine Kunkle, vice president of the Washington, DC-based NBCH, which has 84 member coalitions nationwide, representing 8,000 employers and 30 million covered lives. “Employers who know about their employee population can look at certain plans to see how well their disease management programs are performing. This approach goes beyond HEDIS measures for those employers who want more specific information.”

This level of specificity can’t be obtained over night, cautions Kunkle, who says it will take time and collaboration. “But we believe that it will come eventually,” she says. One of the roadblocks has been upgrading computer capabilities for the healthcare system as a whole and accrediting bodies in particular. She contends that once computerized records are in place, measurement of performance and quality will be much easier because uniform data collection will move forward at a rapid pace.

Standardization of such data will be welcomed by the business community. “What I’m hearing from many employers is why can’t people get together with these data?” says Mercer’s Kotin. For example, employers don’t understand how NCQA data from two different health plans that use 85 percent of the same doctors in their networks can look very different, he says. “There’s been a significant amount of dialogue about the usefulness, completeness, accuracy, and even relevance of these data in any given marketplace,” Kotin says. “Most would conclude that they are not getting a true picture of what a physician or medical group is actually doing. But that’s what employers really want to see.”

Kotin believes that the lack of uniform data collection is at fault. Although NCQA is very clear about the data it requires, he says, the health plan’s diligence in its collection process can alter the results. “So you’re comparing apples to apples, but you’re getting Macintosh and Romans.”

More than One Road to Quality

Despite the criticism, many within the business community are using accreditation-driven data and information to evaluate health plans and institutions. “Many employers use the data in decisions regarding health plan contracting, rate negotiations, and

enrollee education," Delbanco says. Once again, there is a wide range, with the larger, more healthcare-savvy companies taking the lead.

As part of the data collection process for its clients, Hewitt sends out a request for information asking health plans to share the bulk of their HEDIS measures, which are then scored. "The more sophisticated employers use that scoring to support some of the value/quality decisions they make when selecting a health plan," explains McMahon.

A handful of those employers are also sharing the data with their employees in the form of scorecards, fact sheets, or report cards. Such documents may contain HEDIS measures, such as rates for mammography screening, childhood immunizations, and cholesterol screening for various health plans and how they measure up against national standards. They may identify characteristics of the health plan, such as wellness program offerings.

Also included may be information pertaining to customer service issues, such as how long it takes for a customer service representative to answer the phone or how quickly a member can get an appointment with a participating provider and whether these fall into acceptable benchmarks, McMahon says. "So employers are using HEDIS data to educate employees on the kind of information they should be looking for when selecting a plan."

More and more employers are taking advantage of the fact that these data are being released earlier in the year, allowing them to compile the data for open enrollment in the fall, notes Mortimer, whose organization represents 90 companies in 11 Midwestern states. They are paying particular attention to measures related to chronic illness and how well plans are addressing these because of the underuse of screening and prevention programs. Companies are also beginning to tie their payroll deduction level to the plan's performance measures as a way to encourage employees to choose the plan with the best performance ratings and least cost, he says.

While large employers recognize that accrediting agencies have raised the bar in terms of general performance within healthcare organizations, they still continue to seek other quality measures for the delivery systems they purchase, notes McMahon. "Even though accreditation may be a differentiating factor," she concludes, "large employers are still looking for additional ways to measure quality. That includes looking at individual components within the plan, such as disease management, patient safety, and customer service as key indicators of quality."

An Abundance of Accredition Agencies

Numerous accrediting agencies exist in the healthcare sector. Here are a few of the most commonly known to employers who use accreditation as one indicator that healthcare organizations are providing quality care.

National Committee for Quality Assurance (NCQA)—accredits managed care organizations, preferred provider organizations, managed behavioral healthcare organizations, medical research facilities, physician organizations, credentials verification organizations, and organizations providing utilization management or credentialing services. Contact: 2000 L St., NW, Suite 500, Washington, DC 20036; (202) 955-5697, www.ncqa.org.

The American Accreditation Healthcare Commission, formerly the Utilization Review Accreditation Commission (AAHC/URAC)—offers 10 different accreditation programs for managed care organizations, including credentials verification, healthcare practitioner credentialing, case management, and health utilization. Contact: 1275 K. Street NW, Suite 1100, Washington, DC 20005; (202) 216-9010, www.urac.org.

The Joint Commission on Accreditation of Healthcare Organizations—accredits hospitals, healthcare networks, home care organizations, long-term care facilities, assisted living residences, behavioral healthcare organizations, ambulatory care providers, and clinical laboratories. Contact: One Renaissance Boulevard, Oakbrook Terrace, IL 60181; (630) 792-5000, www.jcaho.org.

The International Organization for Standardization (ISO)—offers voluntary guidelines for performance improvement of process-based quality management systems by healthcare organizations, ranging from hospitals to home health agencies. Contact: 25 W. 43rd Street, Fourth Floor, New York, NY 10036; (212) 642-4900, www.iso.ch.

ISO Guidelines Target Healthcare Providers

Staking a claim in the healthcare arena, the International Organization for Standardization (ISO) published guidelines for implementing its quality management systems directed at healthcare providers last fall.

The voluntary guidelines published in September 2001 are based on ISO 9004:2000, *Quality management systems—Guidelines for performance improvements*, with specific guidance for its implementation in the healthcare sector. The document provides a framework for the design and improvement of process-based quality management systems by healthcare organizations, ranging from hospitals and home health agencies to physician practices and laboratories.

The guidelines are based on a draft document developed by the American Society for Quality and the Automotive Industry Action Group, the latter of which is a global industry association representing automotive companies, including the "Big Three:" Ford, DaimlerChrysler, and General Motors. This draft was reviewed by approximately 135 healthcare professionals from 20 countries during an ISO workshop held in Detroit last January. Those in attendance included health-service providers, consultants, accrediting bodies, healthcare associations, government representatives, and third-party payers.

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