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Accrediting bodies' latest initiatives

Some of what the Joint Commission, CARF, and COA have in the works **BY BRION P. McALARNEY**

Accrediting organizations rarely sit still; they continuously refine their standards and requirements to improve patient care and organizational practices, as well as look for ways to improve the accreditation process itself. Below are highlights of what's happening at the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), and the Council on Accreditation (COA).

Giving Providers Time to Digest Changes



Mary Cesare-Murphy, PhD

It's been a busy time at the Joint Commission. Beginning this October, the Joint Commission is implementing measures for inpatient psychiatric care (see sidebar).

It also is taking advantage of evolving technologies to make its standards more user-friendly, clear, and concise by implementing a standards improvement initiative.

"We are going through a process of reviewing our standards for clarity and relevance to the field, tailoring the standards' language a bit more, deleting redundant standards that are mentioned in more than one place," explains Mary Cesare-Murphy, PhD, executive director of the Joint Commission's behavioral healthcare accreditation program.

The Joint Commission will provide more information on the standards themselves in terms of rationale and overview. Most changes will appear in the 2010 manual, although an enhanced scoring process will be introduced in the 2009 manual. Starting next year, the scoring process will be based on the "criticality of survey findings."



Accreditation decisions and the timing of follow-up requirements will be evaluated as they relate to the immediacy of the threat to patients' care and safety, as the result of noncompliance with Joint Commission requirements. For instance, "immediate threat to life" situations, such as inoperable fire alarms or high rates of infection, would result in an expedited preliminary denial of accreditation decision, while "less immediate impact requirements," such as failing to set priorities for data collection, could be addressed within 60 days.

Also in 2009 a new leadership standard addressing a culture of safety and quality will debut, and it includes disruptive and inappropriate behaviors in two of its elements of performance. In fall 2009, accredited organizations will receive a complimentary electronic version of the 2010 manual. This new electronic version will have a search capability that will allow providers to

focus on the standards that apply to their programs. "We got feedback that people really wanted an electronic version that would tell them what's applicable to them," reports Dr. Cesare-Murphy. "There's better technology today, and we wanted to respond to that just as we respond to other trends that occur in the field."

Because of these new changes, the 2010 manual will not have any new requirements. "That's enough change for people to digest," Dr. Cesare-Murphy explains. The Joint Commission is, however, identifying areas for future work, affectionately called "parking lots." These include standards for working with people with intellectual disabilities, expectations pertaining to best practices and evidence-based practices, and standards for treatment planning. The Joint Commission is encouraging providers to visit <http://wikihealthcare.jointcommission.org> to provide their feedback on what areas Joint Commission accreditation should focus on to improve healthcare quality.

Setting a New Standard for Seclusion and Restraint



Nikki Migas

Looking toward its 2009 standards, CARF's major area of change will be seclusion and restraint. It has been several years since CARF has changed these standards.

"Because of the significant changes that were going on in the field related to the whole area of seclusion and restraint, and the fact that so many organizations are focusing on eliminating the use at all of seclusion and restraint, we had a group of

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Joint Commission moves forward with HBIPS measure set

providers and regulators and persons served come together to review those standards," says Nikki Migas, CARF's managing director of behavioral health and child and youth services. "We ended up focusing on standards that would be more in line with nonviolent intervention."

The standards will describe steps that should be taken first to avert the need to implement a seclusion and restraint procedure, as well as educate providers to view seclusion and restraint as a treatment failure because of an inability to appropriately connect with the person being served, Migas explains.

Later this year CARF will post the proposed standards at www.carf.org for about three weeks, allowing for provider feedback. The standards will be published in January 2009 and become effective in July 2009.

Preparing to Handle the Worst



Richard Klarberg

COA has several ongoing initiatives, covering areas as diverse as adult guardianship, disaster services, juvenile justice services, and after-school programs. COA is working with a number of accredited organizations that are very involved with guardianship, including Catholic Charities USA and Jewish Family & Children's Service, to develop adult guardianship standards for organizations that serve adults only, expected to be published in January.

"As the country becomes increasingly older, there's a greater need to protect vulnerable senior citizens," says COA President and CEO Richard Klarberg. "Because we have such a mobile nation, older people are left on their own and find it difficult to cope, and they become potential victims for unscrupulous individuals, so the guardianship standards look to protect the rights of seniors."

COA also was involved in developing standards for disaster-relief case management, which are about to be published. In

The Joint Commission has decided to implement the Hospital-Based Inpatient Psychiatric Services (HBIPS) measure set while it waits for the measures' endorsement by the National Quality Forum (NQF) and approval by the Hospital Quality Alliance (HQA). The measure set evolved out of a partnership between the National Association of Psychiatric Health Systems (NAPHS), National Association of State Mental Health Program Directors (NASMHPD), and NASMHPD's Research Institute (NRI) that began in 2002, and later involved the American Psychiatric Association and the Joint Commission. According to the Joint Commission's Web site, specifications for the following measures have been completed:

- Admission screening for violence risk, substance use, psychological trauma history, and patient strengths completed
- Hours of physical restraint use
- Hours of seclusion use
- Patients discharged on multiple antipsychotic medications
- Patients discharged on multiple antipsychotic medications with appropriate justification

concert with a large group of other organizations, COA worked with the National Voluntary Organizations Active in Disaster (NVOAD) to develop the standards.

"As we saw with Katrina, there was definitely a void in how the needs of people [displaced by disasters] were being managed and how they were being literally tracked," says Klarberg. "So we developed these standards...that will allow agencies to be identified as having in place standards that will help in the area of case management in the event of natural disaster and of course, sadly, in the event of a man-made disaster."

Calling this an exciting and important initiative, Klarberg says that COA wants to ensure that people's needs are being met beyond the immediate situation to help them rebuild their lives. "What we want to put in place through disaster relief case management is that agencies have the capacity to be responsive in a very struc-

- Post-discharge continuing-care plan created
- Post-discharge continuing-care plan transmitted to next level of care provider upon discharge

The HBIPS measure set will be available starting with October 1 discharges for free-standing psychiatric hospitals and acute-care hospitals with psychiatric units. Until the Joint Commission receives the nod from NQF and HQA, data on the measures will not be publicly available through QualityCheck.org and will not be included in the Joint Commission's Priority Focus Process (PFP) or Strategic Surveillance System (S3). Yet the data will be available to Joint Commission surveyors and will be in each hospital's ORYX Performance Measurement Report (available via secure extranet site).

To read about some of the history of the HBIPS measure set, visit www.behavioral.net/mccann0906. For the latest updates on the set, visit www.jointcommission.org/PerformanceMeasurement/PerformanceMeasurement/Hospital+Based+Inpatient+Psychiatric+Services.htm.

—Douglas J. Edwards

tured and systematic way to deal with the needs of these people," he says.

The standards evaluate an organization's ability to go beyond being a first responder, at which point it becomes a much more difficult task to identify individuals' and families' needs, notes Klarberg. While this includes basic needs (e.g., food and shelter), it also includes people's ability to cope with what has just happened in their lives, he explains.

"We've seen in many instances, whether it was 9/11 or Katrina, that there are heroic deeds done by men and women, both professionals and volunteers, and then at a certain point, the support systems, if they don't disappear, they become substantially diminished," says Klarberg. It then becomes increasingly difficult to meet the needs of those impacted, he adds. ■

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