Integration among the trends in accreditation

November 23, 2016
by Alison Knopf

Here are four major accreditation organizations in the behavioral health field, each with its own type of service. All are facing substantial changes in the marketplace and have created new strategies to respond accordingly.

The organizations include:

- CARF International (CARF);
- Joint Commission;
- Accreditation Commission for Health Care (ACHC); and
- Council on Accreditation (COA).

Today's trends

Moving away from institutions and toward community-based care has been a longstanding approach for the behavioral health field, but the infrastructure to support the market shift historically didn’t always follow, says Michael Johnson, managing director with the behavioral health division of CARF, which started in 1982. Today, however, community-based systems have seen some growth, which leads to the need for more effective integration, he tells Behavioral Healthcare Executive.
In terms of emerging trends, Richard Klarberg, president and CEO of COA, is concerned about broader social issues: increasing numbers of women in prison; an ongoing rise in suicides; and the high number of overdose deaths per day nationwide. Clearly, the need for effective service organizations during anxious times in communities is critical.

“What we’re really looking at is the fact that behavioral healthcare agencies are going to become more and more valuable as children and families in their communities seek shelter from this storm,” says Klarberg. “These agencies will become emotional first aid stations, first responders along with police, firefighters, EMTs and social workers.”

Accrediting bodies also serve to advocate for the agencies they accredit, says Klarberg.

“We need to respond to behavioral health issues as they emerge,” he says.

COA is transforming its process so that by 2020, it will allow for more flexibility to respond to the market needs. Accrediting bodies also need to help drive an increase in funding for agencies helping communities that are dealing with complex issues.

“We can’t just maintain the status quo, because if we do, our agencies will be consumed by it,” he says. “They need to be prepared to deal with emergencies.”

As behavioral health providers enhance their services and expand their capabilities, standards for accreditation will also expand, the experts say.

### New eating disorder measures

This year, the Joint Commission issued new eating disorder standards because some basic quality and safety issues weren’t being met at the provider level, says Tracy Griffin Collander, executive director of behavioral healthcare accreditation for the Joint Commission. Most of the eating disorder treatment providers the organization accredits are serving patients with anorexia or bulimia, she says.

Patients with eating disorders can be especially fragile, medically and mentally, and also at increased risk for suicide, she says, which requires a more integrated approach to care. So for example, one of the eating disorder standards requires a multidisciplinary care team.

“This doesn’t necessarily mean you have to pay everybody as a staff member, but you do have to engage the primary care physician in your process,” Collander says. “If you’re a residential provider,
you have to know who you’re discharging the patient to, to make sure there’s a solid support system in place when the patient is leaving treatment."

The organization also added some housing support standards, based on “housing first,” a concept that prioritizes housing for people who are not in recovery yet, and on “rapid re-housing,” a homelessness-prevention program. These standards help organizations that are funded by the Department of Veterans Affairs, for example, qualify for long-term grants, says Collander.

In 2017, the Joint Commission also will score its surveys differently using its Survey Analysis For Evaluating Risk (SAFER) method. Instead of providing a treatment center with a feedback report noting requirements for improvement, the new scoring will prioritize the relevant standards and elements within a matrix, based on risk, says Collander.

“This will give organizations the ability to prioritize and focus their corrective actions,” she says.

There will also be an update to the Joint Commission’s outcome measurement standards starting in January. Providers will be required to use a standardized tool to monitor progress, so that they know whether their treatment approach is working in terms of outcomes. In addition, providers will have to aggregate data. Because this is going to take time, the field will have more than the usual six-month period to prepare.

**Behavioral health home**

Kate Peterson, behavioral health surveyor for ACHC, says integrated healthcare standards as well as behavioral health home standards are in beta testing now for the accreditor. Medicaid waivers are driving integration, she says, and best practices are needed. For example, North Carolina is operating under a 1915(b) waiver and has submitted a request for a 1115 waiver that will allow the state program to customize a more comprehensive Medicaid delivery model with the approval of the federal government.

“Through the waivers, we’ve been able to cover some evidence-based practices,” she says, noting that in-home care and family-centered treatment are key trends.

Measuring the success of evidence-based practice is helping, she says, leading to some standardization. For example, data shows families are served best in the family environment.

**Sober homes**

Although there are voluntary operational standards in some states, sober living is not yet examined for accreditation by itself. While CARF has two programs for community housing, sober homes are
distinct. Unless the home is operating as part of a treatment system, most independent providers won’t seek accreditation.

“There needs to be some kind of quality parameter” for sober homes, however, says the Joint Commission’s Collander. To be eligible for accreditation as part of a larger organization, the sober home must include staff providing some kind of service, such as case management, medication management or providing resources to residents, says Collander.

“If it looks like Oxford House, which is completely run by the sober community of peers, and is not providing care, treatment or services, it’s out of the scope,” she says.

Accreditation uptake varies by state, says Johnson. For example, New York has no incentive for accreditation, and there are many unaccredited providers there, he says. Georgia, Louisiana, and Michigan are among states that have had long-term requirements for accreditation in order to obtain Medicaid reimbursement. Increasingly, experts say, commercial insurers will dictate which type of accreditation they expect for their reimbursement models.

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