JCAHO Mental Health Care Network Accreditation as a Performance Improvement Project

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In June 1995 the Southeastern Area of the Massachusetts Department of Mental Health became the third health care network, and first mental health care network, to be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) under its new network standards. This paper provides a brief overview of how the Southeastern Area network prepared for and went through the JCAHO survey. The author shows how the effort of undergoing the accreditation procedure helped improve the performance of the network. To help other organizations considering JCAHO network accreditation, specific aspects of the survey process are presented, including preparing documents, understanding key concepts emphasized by JCAHO, and preparing staff for participation in the survey interviews. (*Psychiatric Services* 48:359–363, 1997)

In 1994 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) published the Accreditation Manual for Health Care Networks (1). The Joint Commission had previously developed standards for health maintenance organizations, which it subsequently dropped because of a seeming lack of interest (2). However, the ensuing years witnessed a rapid change in the landscape of American health care, with the growing importance of new and varied forms of organizations (3–5). At the same time, the economic reality of modern health care has dictated that essentially all of these newer organization types, no matter what group they serve, encompass some form of managed care, with its attendant debate over cost versus quality (6–9).

Providing appropriate care to persons with serious mental illness in the postdeinstitutionalization era is a challenge for any health care delivery system in the best of economic conditions (10–12). Therefore, it is not surprising to find modern managed care organizations borrowing from some of the previously successful strategies of the community mental health movement when attempting to serve this population (13–15).

How do the patients or clients fare under the latest schema? By introducing the new set of standards, the Joint Commission affirmed the increasing prevalence of service delivery within the context of these large, more or less integrated health care systems. Most important, it affirmed the need for an evaluation method "to ensure that appropriate attention is directed to quality patient care under these new arrangements" (1).

JCAHO standards have evolved over time, mirroring the shift from quality assurance to the more dynamic quality improvement or performance improvement (16–22). Building on the quality management work of Deming (23), Crosby (24), Juran (25), and others, which became known in the manufacturing and service industries as total quality management, Berwick and others (26–28) transformed these ideas and techniques for application to the world of health care problems. Continuous quality improvement was the result. The JCAHO makes clear that core concepts of continuous quality improvement and total quality management underlie the current standards and form the basis of its key principle of performance improvement (1).

This paper describes one mental health care delivery system and how it prepared for and went through the JCAHO network accreditation process. The focus is on specific activities and approaches before and during the network accreditation survey, to help other organizations considering a similar undertaking and to show how this effort helped improve the functioning of our own network.

The network

In June 1995 the Southeastern Area of the Massachusetts Department of Mental Health, one of seven mental health areas in the state, became the third health care network—and first mental health care network—to be accredited by JCAHO under its new network standards. The Southeastern Area network provides mental health services to persons in 70 cities

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and towns, with a total catchment-area population of 1.2 million.

The network has approximately 10,000 enrolled members and provides service to somewhat more than half that number in any one month. Most service recipients are either uninsured or have Medicaid coverage. The area is subdivided into six geographic sites and includes three state-owned community mental health centers (CMHCs) and one state hospital. Services are provided at the four state facilities, as well as at more than 100 vendor-contracted sites. The hospital and the CMHCs are all individually accredited by JCAHO.

In early 1993, as the Southeastern Area began operating as a network, a governing body was created. This group is composed of members of the area office, led by the area director, who is appointed by the Massachusetts Department of Mental Health, as well as members from the different sites and the state hospital. The governing body, with the area director as chairperson, functions as the leadership of the network. This body implements department policy, establishes parameters for network-wide activities such as guidelines for clinical practice and performance improvement programs, and fulfills the organizational leadership functions enumerated by JCAHO.

Survey preparation

In July 1994 the governing body took on the task of attempting to achieve network accreditation. A committee was set up to organize the process under the direction of one of the site directors, who functioned as the survey coordinator. Individual teams were formed to focus on each of the seven separate chapters of standards in the JCAHO accreditation manual: rights, responsibilities, and ethics; continuum of care; education and communication; leadership; management of human resources; management of information; and improving performance of the network. (The 1996 JCAHO network manual has an eighth chapter on health promotion and disease prevention.) The teams' job was to identify existing policies, procedures, and other management structures at the individual sites that would comply with the standards in the chapter they were assigned and to develop them when necessary for both the specific sites and the area office to ensure consistency throughout the network.

Examining the standards in detail forced us to look at areas in which we were deficient, and it pointed out ways in which we needed to—and could—improve services. To improve continuity of care, it was decided that all discharged or transferred clients in the network who are referred to another program must be linked with the receiving clinician before discharge or transfer. Also, the assigned clinician in the referring program is required to follow up and contact the client directly until the linkage is completed. Similarly, new measures were put in place to enhance patient education and to clearly describe both patients' rights and the required ethical behavior of network employees.

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Documentation

JCAHO has recently moved away from its strong emphasis on document review during the accreditation survey to a much more interactive process. The surveyors spend considerably more time talking with many different staff members to gain a more personal, first-hand knowledge of how the organization operates. However, adequate documents are still vital, perhaps even more so in the case of network accreditation, to help demonstrate the network's level of systems integration across its various service delivery sites.

To prepare for this aspect of the survey, staff gathered an exhaustive set of documents, bound in separately numbered notebooks, which gave a detailed picture of network operations. Although many of these documents already existed, some were revised as part of the preparation process, and some were newly written to more fully address JCAHO requirements. Writing a comprehensive organization plan including mission, vision, and value statements not only satisfied one of the leadership standards, but, more important, helped network leaders think about and delineate the exact nature of what we were attempting to do and how we could do it.

At the surveys of both network headquarters and the network's unaccredited components (five selected vendor-operated programs), the commission representatives were given a typed and numbered list of the documents, which helped them quickly locate specific items of interest and which they clearly appreciated. This arrangement of the documents also helped the staff by providing another way of visualizing and understanding the background structure of the organization.

Staff preparation

Training in continuous quality improvement methods, which had already been going on for more than a year, continued as part of the preparation for the survey. An increasing number of staff members participated in performance improvement teams. Staff members learned how to make storyboards (posterboard-type representations of the work of a performance improvement team) using JCAHO's performance improvement flowchart, which outlines the activi-

ties of design, measure, assess, improve, and redesign, and focusing on the nine dimensions of performance (1). During the survey these storyboards provided a visual demonstration of some of the continuous quality improvement efforts of the network.

The nine dimensions of performance provide a framework for evaluating whether the organization is doing the right thing (the dimensions of efficacy and appropriateness) and how well it is doing the right thing (availability, timeliness, effectiveness, continuity, safety, efficiency, and respect and caring). The Joint Commission expects that these important dimensions will be built into the design of any service. This model, together with the performance improvement flowchart, are cornerstones of the commission's approach to continuous quality improvement. It is therefore important that staff be well versed in these concepts no matter what specific performance improvement measures are used by the network.

One storyboard based on a performance improvement team's work involved a problem with the supply and demand of acute and continuing care inpatient beds in the network. The team looked at the issue of acute patients' being admitted to the state hospital, which was intended only for continuing care, when the acute units at the CMHC were full. The storyboard outlined the process of the team's analyzing the situation, collecting and interpreting data to address the problem, putting certain changes in place, and examining data for a period after the changes to evaluate their effectiveness. The storyboard also indicated the major functions, based on the JCAHO standards manual, that were reviewed in this project, which included leadership, information management, patients' rights, and continuity of care, and how the dimensions of performance were reflected in the improvements made.

Similar storyboards showed the work of other teams. The teams examined issues such as access to care for multiproblem youths who required the services of multiple agencies (mental health and social services), and the development of a "triggers" system to help identify patients with previous high utilization of inpatient services who might be at risk for further acute hospitalization.

The final process of preparation proved to be one of the most useful for the staff—role playing the different interviews scheduled for the survey. At the beginning of these mock interviews, conducted by the survey coordinator, it became clear that even though staff knew most of the material covered by the questions, people were very reluctant to speak up. One of the key roles of the coordinator is to help staff realize that they already know the important aspects of how the organization works, what systems hold it together, how information flows through it, who is accountable for major areas, how policies and procedures are implemented, and how change is achieved to improve organizational quality.

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In addition to having this knowledge, staff members must be familiar with JCAHO language (such as the nine dimensions of performance) to express their knowledge within that context. For each scheduled interview, one key person was designated to be the lead speaker to respond to the surveyors. With continued rehearsing, staff became much more comfortable at joining in with their own understanding and avoiding long silences or gaps, which proved crucial in making the actual survey a dynamic, interactive process.

The survey

Following an initial review of the network documents, the surveyors began the specific topic interviews, beginning with the leadership conference. The leadership interview is perhaps the single most important one in the survey. The leadership functions of supplying the framework for planning, directing, coordinating, providing, and improving the health care services delivered by the network permeate all aspects of network operations and may be asked about in relation to any subject. For example, although a particular individual may be designated to coordinate staff education, leadership delineates the organization's mission, vision, and values. Therefore, it is a leadership function to teach and coach staff to help realize these core principles.

Because of the centrality of leadership, throughout the survey process the surveyors looked for evidence of how information moves from and to the network's leaders. For example, when the governing body charters a performance improvement team to look at a certain process, is the information loop configured so that the data gathered are available to leadership to aid in redesigning and improving the process? Does important clinical information about a particular licensed independent practitioner, generated as part of risk management studies, get to the appropriate leaders to help the decision-making process in granting, renewing, or revising clinical privileges?

Just as issues of leadership pervade all of the different chapters in the JCAHO manual and appeared in one form or another in all the different survey interviews, so too did performance improvement. In discussions of the medical-professional staff the surveyors raised questions about the performance improvement teams participated in by professional

staff and how information from different performance improvement activities is relayed to the medical-professional staff executive committee. Similarly, in discussions of the network's education of staff and patients, the surveyors asked how performance improvement data are used in pinpointing areas for further educational efforts.

This questioning of data brings up one important aspect of performance improvement for further emphasis. Total quality management and continuous quality improvement are built on a foundation of statistical analysis of data. Rather than relying on anecdotes or assumptions about the reasons a process or activity is not working as desired, quality improvement initiatives require disciplined measurement and subsequent assessment or analysis of data to generate useful information. During various parts of the JCAHO survey, the surveyors will ask to be shown how the network actually arrives at and utilizes aggregate data to support management decisions. The storyboards can be an excellent visual demonstration and focus of discussion in showing how the organization complies with this requirement.

Discussion

Having received network accreditation, we now must look at how to improve services and operations in the future, which is the assumption underlying "continuous" in continuous quality improvement. Besides working on the commission's specific recommendations in areas in which we were not in full compliance with the standards, we must consider the broader issue of JCAHO's future direction. Clearly, the commission seems increasingly concerned with evaluating not just what an organization is capable of doing, as measured by compliance with standards, but also what it is in fact doing.

Although the surveyors at network headquarters accepted our early efforts at performance improvement projects, they mentioned repeatedly that in the future they will want to see the actual outcomes of these efforts. In subsequent surveys they will want evidence not just of data collection and analysis in a particular area but of how a process or activity has been improved based on the information generated. And, if an effort to change has not resulted in improvement, the surveyors will want to understand how the organization used those data to further refine and redesign the process in an ongoing attempt to reach the desired outcome.

The focus on outcomes data is part of the commission's general interest in moving to an ongoing performance measurement system, with indicators for clinical performance, system performance, and prevention and screening (29,30). The commission hopes that by combining continuous indicator tracking with the survey of compliance with standards, a far more comprehensive picture of a network's health care delivery system will emerge and thereby provide a more useful and reliable accreditation process.

Preparing for and undergoing the network accreditation survey was not without its difficulties. Learning the language of total quality management and continuous quality management, and, more significantly, learning how to apply it, requires staff to invest a great amount of time and energy. However, this level of investment is currently necessary even for an individual facility being surveyed. For a network, staff must also learn new conceptual models of how larger, more complex organizational systems achieve integration and function effectively.

A greater challenge is the loss of autonomy that the various service delivery sites experience when they become part of a network, even when local flexibility is allowed within the network's broader requirement for consistency in programming. It is no easy struggle to persuade either management or professional clinical staff to compromise on some of their turf issues to work for the larger partnership. In preparing for the network survey interviews, it is necessary to regularly remind staff that even though they can present examples of how activities are carried out in their local setting, the emphasis must be on how these activities reflect networkwide operations and how staff at one service delivery site relate to clinical service providers or managers in other parts of the system.

Conclusions

This paper has described one mental health care delivery system that became an integrated network and achieved JCAHO network accreditation. Was it worth the effort? This is really two questions. Was it worthwhile for the different service delivery sites in the Southeastern Area of the Massachusetts Department of Mental Health to integrate sufficiently to be truly capable of functioning as a network? And, when organizations form a functioning network, is it necessary to seek JCAHO accreditation or some other external accreditation?

In answering the first question, important managerial and financial aspects of integration should be considered, such as more efficient use of resources, creation of a useful networkwide management information system, and increased contracting possibilities in a changing health care environment based on scale and efficiency of operations. However, most significant for us has been the effect on patient care. By ensuring consistently high standards of clinical services in all locations and by greatly expanding the channels of communication between staff in those different service delivery sites—whether hospital or outpatient clinic, residential program, or crisis stabilization unit—a high-quality continuum of care is provided to best meet the needs of the clients served.

In regard to the accreditation process itself, it might be argued that organizing and functioning as a network is fine if that best suits the needs of a particular health care delivery system, but that it should be done without bringing in an outside evaluating agency. Perhaps. But our experience has been that attempting to achieve outside accreditation forced us to look at the service system in a much deeper and more comprehensive way, seeing areas of need and finding avenues of change

that improved the system even while bringing us into compliance with the standards. In this way the network accreditation process itself functioned as our most useful performance improvement effort. ♦

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Almost 20 new videos have been added to the video rental library maintained by the Psychiatric Services Resource Center, one of the most extensive collections of psychiatric–mental health videos in the nation. Free copies of the new 1997 video catalog are available on request.

Among the topics covered by the new videos are brief psychotherapy, electroconvulsive therapy, homelessness, communicating with people with disabilities, and attention-deficit/hyperactivity disorder in children.

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A copy of the catalog was mailed in February to each member organization of the Resource Center and others who requested catalogs within the past year. Other persons may obtain a free copy of the catalog by contacting Letha Muhammad, Psychiatric Services Resource Center, American Psychiatric Association, 1400 K Street, N.W., Washington, D.C. 20005; telephone, 800-366-8455; fax, 202-682-6189.