MARY CESARE-MURPHY, PH.D.
Why our field is leading the way in consumer-centered care

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Mary Cesare-Murphy: Steps to leadership in consumer-centered care

How changes in the field, and in the accreditation process, put behavioral health out in front.  By Alison Knopf

The behavioral health field has led the rest of medicine into an accreditation process that is based on the experience of the person receiving the care, according to Mary Cesare-Murphy, Ph.D., executive director of Behavioral Health Care Accreditation for the Joint Commission.

"Why is behavioral health in the lead? Because there is something special about the field, she told Behavioral Healthcare magazine in a recent interview. "They are true believers," she said. "Throughout my tenure, the behavioral health field — and I mean this in the broadest sense of mental health, substance abuse, and developmental disabilities — has had an approach to accreditation that has been driven by wanting to constantly improve the care, treatment, and services they provide."

While other healthcare providers subject to accreditation are motivated primarily by regulatory and payment concerns, behavioral health providers are "internally motivated," said Murphy.

While these organizations want the secondary gains that come with accreditation, they also want the accreditation process to make them better at what they are doing, she said. "This has been true throughout my career. So we have gotten better over the last 20 years at being helpful to them." Thus, the Joint Commission’s accreditation process now includes many value-added tools that organizations can use for improvement, she said. She added that accredited organizations also can use Joint Commission’s reach to learn more about promising practices of other accredited sites.

"But perhaps the most radical transformation over the course of Dr. Cesare-Murphy’s tenure is the accreditation survey itself. When she started out as an intermittent surveyor, she recalled that the original surveys were based completely on documentation, "Today we use the tracer methodology (Figure 1), and look at services from the perspective of the recipient. Is it centered on the needs of the person and those of the family? Are the services fulfilling their expectations?"

Sea-change on seclusion and restraint

Asked for a specific issue that marked the move toward patient-centered accreditation, Dr. Cesare-Murphy pointed to the focus on reducing restraint and seclusion practices within the mental health field. "This is strictly my opinion, but after the expose by the Hartford Courant ["Deadly Restraint," 1998], the Joint Commission, including the board of commissioners, took this issue very seriously," she said. "We conducted public hearings across the country. We listened to people who had been in restraints. We listened to families."

The voices of consumers and families, who decried the abuse of restraint and seclusion, began to turn the tide within the Joint Commission. A series of public hearings, which Dr. Cesare-Murphy attended, convinced her that consumer input was central to an effective behavioral health accreditation process. "I was one of a few staff members who were intimately involved," with the restraint and seclusion hearings, she said. "As a psychologist, it was..."
CARF and ACHC moving toward health homes, home care

Accreditation is considered increasingly important, not only to assure the consistency of care for those who receive behavioral health services, but for the payers—Medicare, Medicaid, and private insurance—who will be covering services when the Affordable Care Act takes effect. In addition to the Joint Commission, two other accrediting organizations, the Accreditation Commission for Health Care (ACHC) and CARF International, continue to adapt their accreditation programs to the changing face of mental health and substance use disorder treatment.

ACHC

The ACHC, which has its roots in the home health care business and is the deeming authority for Medicare home health, hospice, and DMEPOS, is conducting beta tests starting this spring for its new Behavioral Health Accreditation Program. The first survey, of the Mental Health Center of East Central Kansas, was to occur in April, and be used to validate eight of the nineteen service standards for the new program.

Beth Gregory, Ph.D., Chronic Care Program Manager at Behavioral Health Amedisys Inc., reported in a recent ACHC press release that participating in the beta testing was valuable because it “allowed us to evaluate our own program and assure it provides the highest level of patient care.” And David Swann, Chief Executive Officer of Crossroads Behavioral Healthcare, said the standards “will result in the improvement of the quality of health care delivered.” Participating beta test organizations have the opportunity to receive accreditation at no cost.

Raleigh, North Carolina-based ACHC announced last month that Senior Home Care, based in Clearwater, Florida, was the first home health organization to be accredited for Behavioral Health Home Care (BHHC), a specialty accreditation released a year ago. Behavioral health home care delivers behavioral health interventions for people whose mental illness, substance abuse, or intellectual disabilities prevent them from receiving care outside their home. A psychiatric nurse or other home care professional delivers the services, which must be ordered by a physician.

According to Britt Welch, Behavioral Health Clinical Manager at ACHC, the voluntary pursuit of the BHHC means an organization “recognizes and seeks to provide the highest quality of care to this unique and growing population in the home care industry.” Robert Fusco, Chief Executive Officer of Senior Home Care, said in the ACHC press release announcing the certification that he was proud of meeting the requirements for “patient care, administration, transparency and accountability” and also of the “commitment and compassion that our clinicians have in caring for our patients with behavioral health needs.” Lynne Hebert, also of Senior Home Care, called the accreditation process “an eye-opening experience,” adding that it was valuable in “guiding us to do the right thing to improve.”

ACHC started based on a model to “ensure a voice for providers,” while the standards themselves are patient-centered.

CARF

CARF strongly promotes its mission: to focus on “enhancing the lives of persons served.” CARF views its “moral owners” as “persons served”—the consumers of services, or when the consumers are unable to represent themselves in the decision-making process, their legal representatives, such as family members.

At the same time, CARF recognizes that third-party payers, including states, have come to rely on accreditation as fast-moving changes to primary care—behavioral health integration fall into place. There are new CARF standards for integrated programs. Increasingly, budget cuts mean that managed-care and state payers are mandating accreditation as an assurance of consistency and quality, since insurance companies and state departments often lack the staff to ensure quality themselves.

This summer, CARF International released standards for the accreditation of health homes that will focus on the whole person while providing primary care and behavioral healthcare. “A health home is not a facility or dwelling,” said Nikki Migas, managing director of CARF International’s Behavioral Health Accreditation area in a recent press release. “Rather, it is a central point to coordinate an array of primary and acute physical health services (including prevention and wellness promotion), behavioral healthcare, and long-term community-based services and supports, especially for persons with chronic conditions.”

Under the Affordable Care Act (ACA), states can pay for health home services for Medicaid beneficiaries who have at least two chronic conditions, one chronic condition with a risk for another, or one serious and persistent mental illness. The chronic condition could be asthma, diabetes, heart disease, obesity, a mental condition, or a substance use disorder.

She notes that the Joint Commission created these standards prior to the Supreme Court’s Olmstead ruling. “Not to give us too much credit, but the Joint Commission was ahead of the curve” in recognizing that many treatment services occurred outside of hospitals. At first, home services weren’t included, though they are now.

In part because so many services are now delivered outside of hospitals, Dr. Cesare-Murphy does not refer to recipients of services as patients. “Over my career, people who receive services have been called all kinds of things, and in our hospitals we

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also eye-opening for me.”

The hearings marked a turning point at the Joint Commission. From then on, there was an appreciation of the “value of the input and perspective of the people who receive services,” she said. “It changed the direction of all of our processes, because it changed how people thought about care.” The new restraint and seclusion standards came out in 2000.

From that sea-change in perspective, many other and more gradual changes followed. Behavioral health took note of a growing recovery movement, while awareness of the emerging role of peers and peer support services grew.

Recognizing treatment beyond the hospital

As recently as 20 years ago, the Joint Commission accredited psychiatric hospitals, as well as residential and community-based services, under the same set of standards. “It very quickly became obvious that these are two different settings, and that we needed separate manuals for things other than hospitals, that are based in the community or in the home,” said Dr. Cesare-Murphy.

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In part because so many services are now delivered outside of hospitals, Dr. Cesare-Murphy does not refer to recipients of services as patients. “Over my career, people who receive services have been called all kinds of things, and in our hospitals we
use the word ‘patient,’” she said. “We now talk about the ‘individual being served.’” The word “person” isn’t used, because this word is used in other contexts, she said. And she noted that in avoiding the use of “patient,” the Joint Commission is following the wishes of the people who do, in fact, deliver and use the services. “Some of our organizations talk about ‘consumers.’ Some say ‘people.’ Very few say ‘patient.’ We try to respect the terminology they use.”

When surveyors want to find out about the experience of children in a behavioral health organization, they may ask the family on the telephone, said Dr. Cesare-Murphy. If the child is in a residential program, they may ask one of the young people to give them a tour, or may sit down and have lunch with the children, she said. “They don’t say, ‘I’m going to have an interview with this child.’”

Noting that the Joint Commission also surveys people who get surgery, for example, about their experiences, Dr. Cesare-Murphy said that the behavioral health field is leading the way. “The behavioral health field is an unsung leader in appreciating the voice of the consumer,” she said. “We—the collective behavioral health field—started talking about person-centered care long before the more traditional areas of health care.” While these fields “are just starting to talk about patient-centered care, we invented it a long time ago.”

Another change that Dr. Cesare-Murphy has seen is a greater cooperation between those in mental health and substance abuse treatment. “When I first started out, mental health and substance abuse treatment were so entirely separate that there was almost animosity between them,” she said, noting that the hard feelings were largely the result of separate funding streams. “That has changed remarkably. The commonalities are being recognized, with both kinds of treatment being integrated.”

Benefits of accreditation
Dr. Cesare-Murphy, who has worked her entire career in the behavioral health field, believes that accreditation—something that only a minority of behavioral health organizations have opted for—assures families that programs have “voluntarily
met very demanding standards focusing on quality and safety." But does accreditation guarantee a higher quality of care? "As the song says, life has no guarantees," she said. "But I can say that as a result of being accredited, the family can be sure that someone has reviewed the program temporally against standards, and that compliance is ongoing, not periodic."

"I can't guarantee that something can't go wrong, but the probabilities are greatly reduced," she said. She asserts that accreditation is a self-selecting process. Among organizations that want to be accredited, she said that some drop out during the process "because they can't do it," a scenario that is far more likely than a denial of accreditation. Others "know that it's a good idea, but say they're too busy. While accreditation may be associated with larger organizations, "We've accredited organizations that have as few as five staff, and one with fewer than that," she said.

Interestingly, the accreditation process is silent on the topic of utilizing health information technology such as electronic health records (EHRs). "We have no standards requiring organizations to have electronic records at this time," said Dr. Cesare-Murphy, who points out that accredited programs nevertheless must have the ability to collect and chart key data associated with the process.

Integration with primary care

Though the behavioral healthcare field often thinks of itself as special, it must consider itself to be part of the traditional healthcare world. "We need to be at the table with healthcare," she said, noting that "As the Affordable Care Act becomes a reality, what people are talking about is the integration of behavioral health and primary care."

Dr. Cesare-Murphy believes that it's essential for behavioral health to be an equal partner—not a subordinate—in the new integration scenario. "Behavioral health must have a robust voice and role in this health home of the future," she said. "If they don't, they're just going to be absorbed, and I don't think that's in the best interest of anyone."

She maintains that accreditation has a lot to do with the perception of an organization and a field. Accreditation means that "you
are of the same caliber and quality as some of those other primary care providers,” she said. “[It also] lends credibility and respect ... and puts you in a position to have a seat at the table.”

This year, the Joint Commission added standards for primary physical care to the behavioral health manual for organizations that are providing integrated care. By 2014, the Joint Commission will offer an additional certification for organizations that want to be certified as behavioral healthcare homes, in addition to the current behavioral healthcare certification. “We’re going towards health homes,” she said.

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FIGURE 1: TRACER METHODOLOGY, DEFINED

Tracer methodology is an evaluation method in which surveyors select a patient, resident, or client and then use that individual’s record as a roadmap to move through the organization. Along the way, surveyors evaluate the organization’s compliance with selected standards and its systems for providing care and services.

Surveyors retrace the specific care processes that an individual experienced by observing and talking to staff in the areas or functions where the individual received care. As surveyors follow the course of treatment for a patient, resident, or client, they also assess the healthcare organization’s compliance with Joint Commission standards. The compliance assessment is conducted as surveyors review the organization’s systems for delivering safe, quality healthcare.

-Source: Joint Commission