



ALLIANCE FOR THE

Safe, Therapeutic & Appropriate Use of Residential Treatment

The Joint Commission's Gold Seal of Approval

Don't be misled by marketing claims about accreditation

When families seek out residential programs for their teens with behavior problems, they often look for seals of approval and other reassurances that a program is effective and under official oversight.

All accreditations, certifications and licensing must be checked at their source to determine what, specifically, is covered by accreditation.

Do not accept information about certification presented to you by a residential program or its website. It is easy to be misled.



In this paper, A START examines a certification known as The Joint Commission's "Gold Seal of Approval." The purpose of this paper is to examine what Joint Commission (JC) accreditation does and does not mean, specifically in the area of behavioral health care organizations and programs for children and youth. A START hopes that this paper will inform both parents and professionals about JC processes and standards so more informed decisions can be made about possible placements.

A START is an organization of professionals, family members, and advocates united in their interest in preventing abuse, neglect, and exploitation of young people in residential care, and their families.

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The Joint Commission: What Accreditation Does and Does Not Mean

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The Joint Commission (JC), founded in 1951 under the name the Joint Commission for the Accreditation of Hospitals, is the nation's oldest and largest health care accrediting body. It currently accredits more than 1900 behavioral health care organizations and programs. The purpose of this paper is to examine what JC accreditation does and does not mean, specifically in the area of behavioral health care organizations and programs for children and youth. The most visible sign of JC accreditation is its well-known "gold seal of approval," which was created in 2003. What does it take to earn this gold-seal of approval?

This paper is prepared and issued by A START—the Alliance for the Safe, Therapeutic, and Appropriate Use of Residential Treatment. A START is an organization of professionals, family members, and advocates who are united in their interest in preventing abuse, neglect, and exploitation of young people and their families in residential care. A START hopes that this paper will inform both parents and professionals about JC processes and standards so more informed decisions can be made about possible placements.

The information in this paper was gathered through a review of published and unpublished literature, two interviews with staff from the JC's Behavioral Health Office, including the Executive Director and Assistant Executive Director, examination of the JC's website, and interviews with providers whose organizations have been surveyed by the JC. In addition, the most current JC manual of standards and procedures was reviewed by two of the A START members, and discussions were held with the entire A START group.

What is the Joint Commission?

The Joint Commission (JC) is an independent, non-profit organization located in the Chicago area that has as its mission the promotion of safety and quality in health care facilities in the United States. Historically, the JC has its roots in the hospital and general medical sector, but in 1970 it established an Accreditation Council for Psychiatric Facilities, and soon after began accrediting psychiatric facilities, substance abuse programs, and community mental health programs. This includes a wide range of mental health and substance abuse programs, such as residential treatment centers, group homes, therapeutic boarding schools, and wilderness camps.

According to its Form 990 report for 2011, a report that non-profit organizations are required to make each year to the Internal Revenue Service, the JC accredits and evaluates about 22,000 health care organizations and programs in the United States. According to the JC website, slightly less than 10% of those, about 1900, are behavioral health care organizations (BHCOs).

This same Form 990 report indicates that in 2011, the JC had revenues of over \$138 million, and expenses of over \$122 million. About \$61 million in revenue was generated by survey fees, and a similar amount by annual subscription fees. In 2011, 20,3000 organizations were enrolled for a subscription fee plan which provided them with access to updated materials and services from the JC.

There are three 501(C) (3) organizations which are affiliated with the JC: Joint Commission Resources, Inc.: Joint Commission Center for Transforming Healthcare; and JCAHO Surveyor and QHR Consultant Corp. The largest of these, the Joint Commission Resources, provides technical assistance services to the types of health care organizations that the JC accredits. Its income in 2010 was \$45.6 million.

The JC operates under the auspices of its President and Chief Executive Officer (currently Mark Chassin, M.D.), who reports to a Board including representations of the American College of Physicians, American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association. In 2007, for the first time a representative of the behavioral health field was appointed as a non-voting member of the Board. This representative was recently made a voting member. Also, representatives of the public at large have been appointed to the Board.

The JC has a section on Behavioral Health which is responsible for developing standards and implementing accreditation processes for BHCOs. There is also an Office of Quality Monitoring which receives and reviews complaints about practices at JC-accredited organizations and programs.

How Do Evaluations for Accreditation Take Place?

Accreditation decisions are based on surveys conducted every three years to determine the degree to which applicants are in compliance with standards that have been developed by the JC, with input from various stakeholder groups. The surveys are conducted by well-trained professionals in their field. The JC operates a certification process of its own to ensure that its surveyors are well-qualified.

In the behavioral health field, a survey would be conducted by two or three licensed mental health professionals and would typically take two or three days, depending on the size of the organization. The fee for the survey depends on the size of the organization as well, and begins at \$2,890.

The survey visits are unannounced in advance to the applicants. However, the applicants do know approximately when they will occur and are allowed to identify up to 10 “blackout” days when surveys will not take place.

Accreditation is a direct agreement in which the program applicant pays a fee to the JC in return for a service.

The survey process evaluates actual care, treatment, and services and analyzes key operational systems that directly impact the quality and safety of the care, treatment, and services. For approximately the past seven years, the JC has used a “tracer” methodology as part of its survey procedure. This procedure involves a review of the care provided to specific individuals through review of records, interview of key staff involved with each individual, and interview, if appropriate, of the resident him or herself and possibly parents. In advance of the site visit, the surveyors identify the criteria for selection of a pool of residents to potentially be “tracers.” These criteria typically ask for a list of individuals who have been in the program for a reasonable period of time and have received a variety of treatments and services. On the first day of the actual visit, the surveyors then select a group of individuals to trace through the program, with the number of individuals depending on the size of the program.

For each of the standards, there are “elements of performance” that the surveyors look for as a means of assessing whether the standard has been adequately met. The standards themselves are based on a recovery-oriented philosophy and approach to care, and try to emphasize consumer rights and choice. However, as the director of the Behavioral Health section of the JC acknowledges, the issue of consumer rights and choices becomes more challenging to assess with minors than it is with adults.

The ultimate decision about accreditation is based on more than a simple aggregation of scores for each standard and its accompanying elements of performance. There are some standards that relate directly to important issues affecting safety and quality, and which by themselves may be sufficient to recommend against accreditation until corrected. The scoring and decision-making process is described in the 2012 Behavioral Health Manual for Child and Adolescent Services of the JC. Applicants will typically use the most recent

manual along with technical assistance from either the Joint Commission Resources, or other knowledgeable individuals/organizations to prepare for a survey.

According to the JC staff, they try to strike a balance between promoting high standards on the one hand, and allowing applicants flexibility in how these standards are met on the other hand. For example, the JC does not prescribe any particular approach to treatment or staffing, nor even require that there be a multi-disciplinary team or a psychiatrist available. Instead the JC allows applicants the flexibility to develop and describe its own treatment philosophy, which is initially done in advance of a survey, and then describe a staffing pattern based on that philosophy. Striking the proper balance between establishing requirements and allowing flexibility is one of the major challenges that the JC faces.

Another major challenge is moving from the establishment of standards to methods for measuring whether they have been met, particularly in a time limited site visit. For example, the JC is quite clear in its standards that corporal punishment, fear-eliciting procedures, intimidation, force or threat are prohibited. They also emphasize the importance of promoting “a culture of safety and respect.” The task of defining these terms clearly and measuring them in a short-time period is much more difficult than simply developing the standards.

Similarly, consistent with system of care values and principles, the standards emphasize the development of individualized treatment plans that are strength-based and the involvement of families in the development of these plans unless “contraindicated.” The determination of the degree to which plans meet these requirements, the manner and frequency of family involved, and the definition of “contraindicated” are all challenging tasks.

Given This Background, What Does JC Accreditation Mean?

1) Does it mean that the accredited program is actually a behavioral health program?

Not necessarily. Within the behavioral health field there is considerable ambiguity about what qualifies a program as a “behavioral health” program. For example, the distinction between a “therapeutic boarding school,” and a regular “boarding school” is not always clear. Nor is the distinction between a wilderness program that is intended to be “therapeutic” versus one that is simply more adventure-oriented.

The JC offers general conceptual definitions. For example, in the glossary of its 2012 “Comprehensive Accreditation Manual, “ “behavioral health care” is defined as “a broad array of care, treatment, or services for individuals with mental health issues or problems, foster care needs, addictive behaviors, chemical dependency issues, or intellectual disabilities.” (p. GL-4). Therapeutic schools are defined as “24-hour residential or day programs that provide an integrated educational milieu with an appropriate level of structure and supervision of physical, emotional, behavioral, familial, social, intellectual, and academic development...Therapeutic schools serve children and youth who have a history of failing to function at home or in less structured or traditional school settings in terms of academic, social, or emotional behavioral development” (p. GL-33-34).

These are broad definitions that are not accompanied by specific criteria that applicant programs must meet in order to qualify for accreditation as a behavioral health entity. In fact, the JC, by its own report, allows programs to self-determine if they are behavioral health programs. One result of this is the existence of a program in New York State that is accredited by the JC as a BHO but has self-identified itself in NY as a boarding school. By identifying itself as a boarding school, it bypasses the process of going through the state licensing process for therapeutic boarding school.

Programs can receive the marketing advantage of being accredited by the Joint Commission as a behavioral health organization, while avoiding state licensing procedures, if state licensing exists at all.

Given the flexibility that the JC allows for a program to identify its own treatment approach and a staffing pattern that goes along with it, and the absence of specific criteria applied by the JC for what constitutes a BHO, programs may have the best of both worlds—they can receive the marketing advantage that comes from being accredited by the JC as a BHO, while avoiding state licensing procedures. This problem is compounded by the fact that some states still lack procedures to license programs as BHOs.

2) **Does accreditation mean that a program has been through a comprehensive independent third-party review?**

Is the review comprehensive? Not necessarily. Indeed, JC standards are extensive and thorough, and their manual has 15 different areas that are assessed as part of its “requirements for accreditation.” The largest of these sections is “Care, Treatment, and Services,” and other sections include such areas as environment of care, human resources, leadership, medication management, performance improvement, and rights and responsibilities of the individual. The standards themselves are not scored in an accreditation site visit but are accompanied by “elements of performance” which amount to more specific actions, processes or structures related to meeting a standard. These elements of performance are judged as satisfactory, partial, or insufficient compliance, and standards are identified as compliant or not based on the scoring pattern of the elements of performance that are associated with them.

The challenge of developing the standards and elements of performance is enormous, and the JC appears to have done an excellent job of this. As daunting as this challenge is, however, the greater one is developing the specific measurement procedures to assess the adequacy of compliance, particularly given the brevity of accreditation visits. Such visits are typically two or three days and involve one, two or three site visitors. In fact, the JC indicates that “most surveys are conducted by a single surveyor; however, based on the size and complexity of the organization being surveyed, an accreditation survey may be conducted by one surveyor or a team of surveyors” (CAMBHC, 2012, ACC-41).

Measuring compliance with standards should not be just determining if a program has a written policy prohibiting harmful treatment of youth.

The examples below are selected to illustrate that while the standards of the JC may be comprehensive, the task of assessing compliance with them in a brief site visit is very challenging.

- The manual includes a standard that says that “the plan for care, treatment or services addresses the family’s involvement” (CTS-42). There are three elements of performance of this standard, including one that indicates that “the plan for care, treatment, or services reflects family participation in care, treatment, or

services unless such participation is contraindicated.” The challenge is in defining “contraindicated” and determining how frequently family members are meaningfully involved in the treatment.

- The JC is very clear in its standard on special behavioral procedures that the following are prohibited: procedures that deny any basic needs, such as nutritious food, water, shelter, and essential and safe clothing; corporal punishment; fear-eliciting procedures; the use of intimidation, force, or threat (CTS-74). This is certainly commendable—the challenge is again one of defining and measuring these, and not just determining if a program has a written policy prohibiting them. Similarly, the JC has an element of performance that indicates that the use of exclusionary time-out should be for no longer than 30 minutes. Determining compliance with this element of performance becomes the difficult and yet critical task.
- The JC stipulates that for organizations that use individualized behavioral contingencies that include the use of aversive contingencies, there should be a prior review both by a clinical leader “and a person(s) external to the organization (for example, an outside expert, an advocate, a human rights committee)” (CTS-80). This leaves considerable discretion to the organization to identify an appropriate individual external to the organization to do the review, and the qualifications and independence of this external reviewer can be very difficult to determine in a brief site visit.

Evaluating performance and compliance— a critical task— is very difficult given the brief time allowed for JC site visits.

Does accreditation indicate that an independent, third-party review has taken place? No. In fact, as indicated earlier, the JC is a large non-profit organization that is in fact independent although its Board of Directors does include representatives of large organizations in the health care field. Perhaps more important, an accreditation review by the JC represents a direct agreement between the applicant and the JC in which the applicant pays a fee to the JC in return for a service. This is not an independent third-party review where, for example, an agency of the government engages an outside organization to conduct the assessment and the

Joint Commission accreditation is not an independent third-party review... It is, in fact, part of a business transaction with the JC.

provider organization is not involved in the choice of the organization. Nor is it a review conducted by an agency of government that receives no fee from the applicant organization.

This is not to discredit the integrity of the JC or of its reviews. It is, however, to point out that the assessment and subsequent decision-making on the part of the JC is all part of a business transaction. For the JC, there is the payment for the survey, payment made for annual updates on standards, and often payment made for resource material and technical assistance offered by the Joint Commission Resources, an affiliate of the JC. For some applicants and accredited organizations, the main benefit that they cite for the review is that it assists them in ensuring that their organization meets high standards for safety and quality. It is also clear, however, that the Gold Seal of Approval that comes with JC accreditation has marketing value to the recipient organization. In some cases, this marketing value may come about because the accreditation has “legitimized” the applicant as a behavioral health organization. It may therefore both help the organization reach out for referrals and also receive third-party payments.

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